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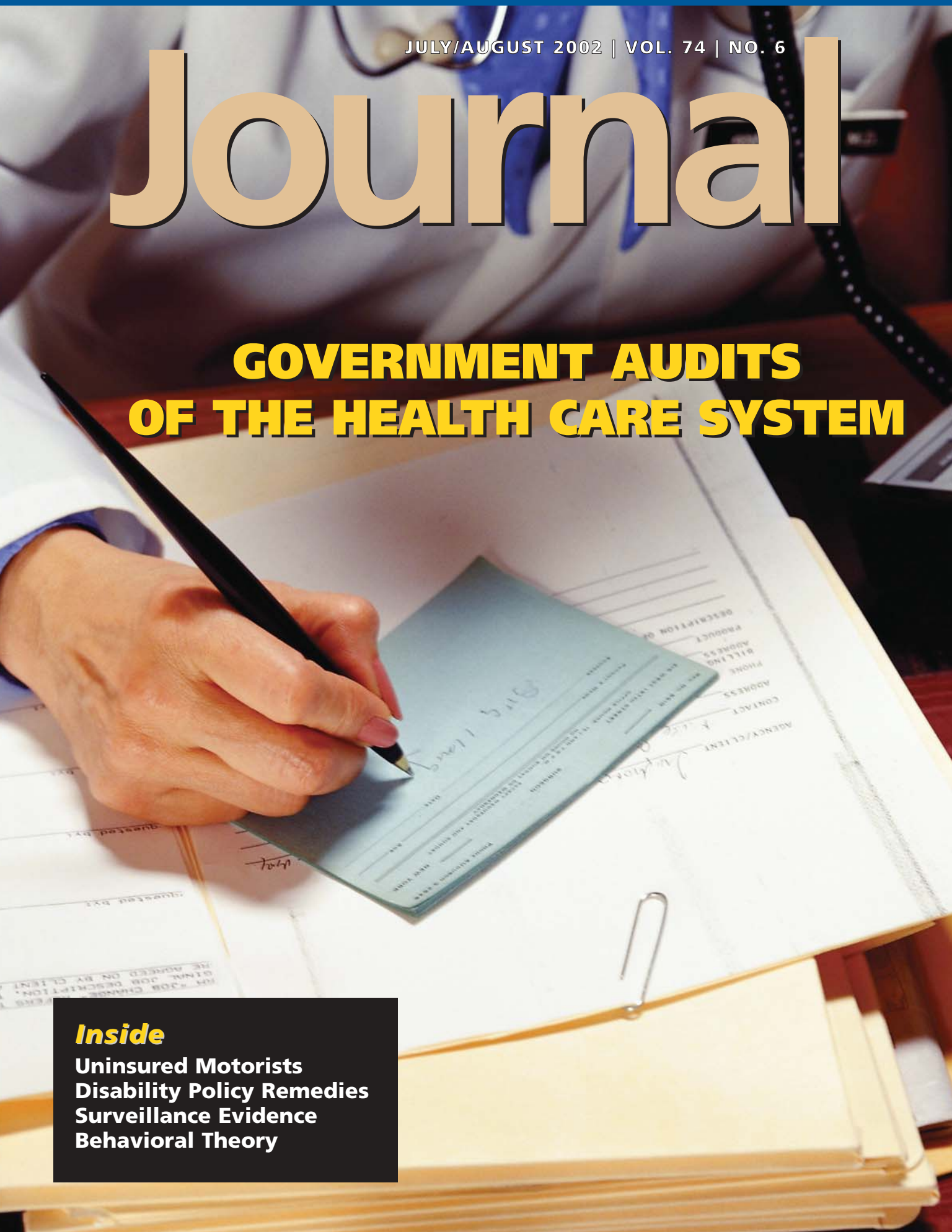
Journal

GOVERNMENT AUDITS OF THE HEALTH CARE SYSTEM



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EDITORIAL OFFICES
One Elk Street
Albany, NY 12207
(518) 463-3200
FAX (518) 463-8844

ADVERTISING REPRESENTATIVE
Network Publications
Sheri Fuller
10155 York Road, Suite 205
Crestridge Corporate Center
Hunt Valley, MD 21030
(410) 628-5760
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ON THE COVER

The record keeping suggested by the illustration on this month's cover was chosen to symbolize the role that accurate records and a comprehensive compliance program must play in efforts by health care facilities to avoid and detect fraudulent behavior.

Cover Design by Lori Herzing.

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President's Message

Lorraine Power Tharp

History Question

• *"Our profession, with becoming gallantry, will welcome the fair sex in this new field of honor and usefulness which has been opened to them. . . . If the influence of woman, usually so potent for good, shall be conducive towards arraying the whole profession more thoroughly on the right side of every public question, the sphere of woman in all occupations may well be generally extended."*

• *"There are more women lawyers in the State of New York than in any other state, but the percentage of female practitioners is only slightly above the national average. . . . [L]istings include 2,997 Portias, 552 of whom are from New York. This means that 1.7 percent of the lawyers in America are women as compared to a percentage of 1.9 percent for New York."*

• *"I think women can have it all. We live so long; you can have the family and then have the career. I didn't do anything real until I was 50."*

The history question for today is: In what years were these statements made? As I develop priority projects for my presidency, it has been helpful to review the conditions of the past and the steps taken by our predecessors in the Association to make improvements. In this message, I will share a brief look-back in time about conditions and actions, and update you on a number of current initiatives to advance our efforts to promote diversity and ensure full participation and opportunity in the profession.

The call to welcome women to the legal profession was made in 1887 by Governor and Association President David B. Hill. (Yes, he served in both positions at the same time. He also signed the bill clarifying that women were eligible for admission to practice.) The second statement comes from a survey conducted 62 years later and published in our *Bar Bulletin*. In addition to finding that the number of women had grown from 1 or 2 to almost 2%, that 1949 research also showed that less than 10% of attorneys in New York were age 33 or younger.

I added the third quotation to bring us to some of today's thinking. That was said by Anne Martindale, who, at the age of 87, received her degree this past May from my alma mater, Smith College. She had wanted to go to law school—her family cut her college education short and made sure that she married instead. Maybe law school is next for her?

Today, women constitute more than 27% of our Association membership and members in their mid-30s and younger make up a like percentage. While strides have been made in increasing diversity, work remains to be done to ensure that policy and procedure reflect the changing face of the profession, that there is opportunity for service in all aspects of the bench and bar, and that doors are open for advancement in careers and in law office, bar association and other leadership positions.

I was gratified that the House of Delegates meeting last month included reports of several committees that generated excellent discussion and plans for action to further inclusiveness and opportunity. The Committee on Women in the Law, chaired by Carla M. Palumbo of Rochester, presented recommendations on gender equity issues to address concerns identified in its survey of male and female members of the Association. Among the findings:

• Discrimination and inequality of treatment based on gender are still prevalent in the profession to a degree that is not acceptable. Women are paid less than men, have less opportunity than men and advance at slower rates than men.

• More than 50% of women experienced or observed some form of gender discrimination involving either the spoken word or demeaning treatment; in some cases, this involved unwanted physical contact.

• Women in the profession are younger than men, many with children under the age of six. Child care issues have a significant impact on women's ability to advance and interact in the profession.

The House unanimously adopted the recommendations of the committee to develop resources to assist in the adoption of fair and equitable policies for members of the profession and to ensure that our Association procedures and programs provide opportunity for participation. While the committee, by its mission, appropriately focused on gender issues, including the increasing numbers of young attorneys, I was pleased when the House modified this resolution to speak more broadly of traditionally unrepresented attorneys. A critical rec-

Lorraine Power Tharp can be reached at Whiteman Osterman & Hanna, One Commerce Plaza, Albany New York 12260, or by e-mail at lptharp@woh.com.

ommendation in the report was establishment of a task force composed of members of the committee and other committees and sections to work for implementation of its proposals for action. I have named as co-chairs of the Task Force, M. Catherine Richardson, past president of the Association, and Ms. Palumbo.

As an alumna of the committee and former chair of its Subcommittee on Women in the Profession, I can attest to the value of this project. The committee noted that these findings have implications for the profession, and our actions to respond to these problems will serve our interests as a whole. Angela Bradstreet, president of the San Francisco Bar Association, observed, "Frequently mislabeled a 'women's' issue, this glass ceiling is, in fact, a fundamental business issue that impedes the growth of law firms and legal departments." Eliminating glass ceilings or other inequitable treatment needs to be everyone's mission.

Of concern, too, is the dearth of diversity on the bench based on ethnicity, race, gender, and practice background in some areas of the state, particularly outside New York City. As I announced at the House meeting, I have appointed a task force, with Margaret J. Gillis of Albany as chair, to examine and make recommendations with respect to all levels of the judiciary and both the appointment and election process.

The House also pursued action on a thoughtful report of the Special Committee on Student Loan Assistance in the Public Interest. This committee, appointed by my predecessor, Steve Krane with Hank Greenberg of Albany as chair, was charged with developing a plan to assist new attorneys who are embarking on public service careers by reducing their educational debt. As approved by the House, the report urged each law school to offer programs to help students seeking employment in public service and public interest law and to work on student indebtedness. The report proposes creation of a student loan repayment assistance pilot program, to be developed in concert with The New York Bar Foundation. A number of our younger delegates rose to describe the plight in handling the increasing cost of legal education in their public interest positions. Others rightfully pointed out the struggles of those beginning in solo and small practices, particularly in upstate New York and certain areas in New York City. The committee's work and the House action advance our efforts to aid our younger colleagues in the public sector. I also was pleased that the delegates expanded the discussion to cite the desire to address the needs of others as they begin their careers. While beyond the purview of the Special Committee, these also are issues that need to be addressed.

The dialogue at the meeting illustrates the caring of colleagues, the potential for further advancement in the goal of full participation and opportunity in the profession, and the importance of our work together through the Association to effect this progress. I recall the observations of past President Maryann Saccomando Freedman on overcoming inequities and injustices: "[W]e have come a long way in 36 years, but from my vantage point, I also know that there is still a long way to go. I have great faith that we will get there. I have that faith because I have great faith in lawyers."

Government Audits Probe Potential Fraud and Abuse By Physicians and Health Facilities

By Robert Wild, Patrick Formato, Michael Schoppmann and Richard J. Weiss
Steven J. Chananie, Nora A. Colangelo, Lourdes M. Martinez

An ever-growing number of government agencies are subjecting all health care providers to regulation, and tremendous resources are being directed into investigating alleged fraud and abuse in the health care system.

Aggressive civil audits and criminal investigations of physicians are becoming commonplace, and both federal and state investigative agencies have targeted physicians for special attention. Every U.S. attorney's office in the nation now has a health care unit. The number of agents from the New York State Department of Health (DOH) and Human Services' Office of Inspector General (OIG) who focus on health care fraud and abuse has increased dramatically.

In New York, the Medicaid Fraud Control Unit of the state attorney general's office is one of the top Medicaid fraud units in the nation, and has been a model for such units in other states.

This article addresses the government's weapon of choice in combating fraud and abuse—the False Claims Act—as well as other laws in the government's arsenal, including anti-kickback statutes and physician self-referral laws. It also provides information on disclosing overpayments received from the government and private insurers and discusses the benefits of implementing a compliance program to avoid and detect fraudulent behavior.

POTENTIAL LIABILITIES FOR DOCUMENTATION, CODING AND BILLING DEFICIENCIES

Although dating back to the U.S. Civil War, the False Claims Act (FCA)[1] remains the government's primary vehicle for imposing civil or criminal liability upon any person or entity deemed to have defrauded the federal government. The FCA has evolved as changes made by Congress in 1986 shifted the Department of Justice's prior focus from the aerospace and defense industries to the health care community. This redirection has altered the course of health care more dramatically than any prior legislation, regulation or government initiative.

Liability Under the FCA

To impose liability under the FCA upon a health care practitioner, the federal government must prove[2] at least the following:

1. the defendant/practitioner must have presented, or caused another person to have presented, a claim for payment to the federal government;
2. the claim must have been false or fraudulent; and
3. the defendant/practitioner must have known that the claim was false or fraudulent.

One of the most litigated aspects of the FCA is the definition of "false" as it relates to claims for health care services. In most circumstances, each action the federal government brings will generate its own definition (and most likely strong disagreement) of "false" based on the case's unique facts and applicable regulations. Changes in regulations over the course of treatment/claim submission and the interplay of the practitioner's intent may have a dramatic impact on how "false" is defined for a particular matter.

In fact, the question of intent under the FCA remains one of the most controversial aspects of the changes

This article is a condensed version of a chapter to be included in the forthcoming *Legal Manual for Physicians*, sponsored by the Health Law Section of the NYSBA and edited by Robert Abrams, Abrams, Fensterman, Fensterman & Flowers, LLP, and Donald Moy, Medical Society of the State of New York, to be published by the New York State Bar Association and the Medical Society of the State of New York.

The authors are: Patrick Formato, Abrams, Fensterman, Fensterman & Flowers, LLP, Lake Success, NY; Michael Schoppmann, Kern, Augustine, Conroy & Schoppmann, PC, Lake Success, NY; Richard J. Weiss, Richard J. Weiss, PC, Garden City, NY; Robert Wild was the coordinating author, with Steven J. Chananie, Lourdes M. Martinez and Compliance Specialist Nora A. Colangelo, all from Garfunkel, Wild & Travis, PC, Great Neck, NY. Frank J. Serbaroli, Cadwalader, Wickersham & Taft, New York, NY, served as reviewer.

Congress enacted in 1986. Health care counsel and the courts have wrestled on a case-by-case basis with establishing a standard unique to health care fraud and abuse actions. The federal government need not prove that a health care practitioner specifically intended to defraud the government by submitting a false claim (exclusive of certain other provisions of the FCA, such as actions for conspiracy to submit false claims, which still require specific intent)—only that the physician knew about the false claim.[3] Under the FCA, "knowing" is defined in terms of a person who "(1) has actual knowledge of the information [and] (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information."[4] The Department of Justice considers the following factors when determining whether a practitioner's claims were made knowingly or with deliberate ignorance or reckless disregard:

- notice to the provider;
- clarity of the rule or policy;
- pervasiveness and magnitude of the false claims;
- compliance plans and other steps to comply with billing rules;
- past remedial efforts;
- guidance by the program agency or its agents;
- prior audits or notice to the provider of the same or similar billing practices; and
- other information that bears on the provider's state of mind in submitting the false claims.[5]

Other Forms of Liability

In certain circumstances, other forms of liability may arise as a result of submitting false claims, each with unique elements and requirements of proof, as described below.

• ***False records*** The use of false records to support false claims may expose the practitioner to additional liability under the FCA. However, the federal government must prove that the false record itself caused the false claim at issue to be paid or approved.[6]

> CASE STUDY: A Richmond County ophthalmologist was accused of violating the FCA by creating new, false medical records upon receiving a denial for payment from Medicare. The new, false record was used to correct any deficiencies cited in the Medicare denial and thereby directly procure approval for payment. After pleading guilty to the charge as entered (and other related charges), the physician was ordered to serve 48 months in federal prison.

• ***False statements*** A practitioner who knowingly and willfully makes a false statement, or falsely represents a material fact in an application for payment or in a determination of rights to payment, or fails to disclose or conceals facts known that affect the right to payment may face criminal liability with fines up to $25,000, imprisonment up to five years or both.[7]

• ***Conspiracy*** Conspiring to submit false claims can be an additional form of liability if the federal government can prove five unique elements: (1) a claim was made to the federal government; (2) the claim was false or fraudulent; (3) the practitioner agreed to the submission of the false or fraudulent claim; (4) an act was committed in furtherance of the agreement; and (5) there was a specific intent to defraud. [8]

> CASE STUDY: A Kings County physician agreed to allow his name and Medicare practitioner number to be used for the submission of claims to Medicare for physical therapy services that were never rendered, in exchange for an annual salary as the practice's medical director. The physician is cooperating with the federal authorities in both the criminal and civil actions brought by the federal authorities against the owners of the medical practice.

One of the most litigated aspects of the FCA is the definition of "false" as it relates to claims for health care services.

• ***Mail fraud or wire fraud*** Under federal law, any practitioner, or someone else acting on his or her behalf, who uses the U.S. mails in carrying out a scheme to defraud may be charged with mail fraud.[9] A practitioner will be found guilty of this offense only if the following facts are proved: (1) the practitioner knowingly and willfully devised a scheme to defraud or to obtain money or property by means of false pretenses, representations or promises; and (2) the practitioner used the U.S. Postal Service by mailing, or by causing to be mailed, some matter or thing for the purpose of executing the scheme to defraud. Similarly, any practitioner who uses interstate telephone transmissions in carrying out a scheme to defraud may be charged with the federal crime of wire fraud.[10]

Penalties

A practitioner who violates the FCA faces civil penalties of not less than $5,000 and not more than $10,000 for each false claim submitted, plus three times the amount of any damages the federal government has sustained.[11] Practitioners guilty of mail fraud or wire fraud face the potential imposition of fines equal to the greater of $250,000 or twice the gross gain or loss from the offense and imprisonment for up to five years.

The federal government may seek criminal penalties for a variety of other actions, including but not limited to providing false statements,[12] obstructing a criminal investigation of health care offenses[13] and violations of the health care offense provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[14]

ANTI-KICKBACK LAWS

Federal

The federal anti-kickback law prohibits the following:

(a) The solicitation or receipt of any remuneration: (1) in return for referring an individual for the furnishing or arranging for the furnishing of any item or service payable by Medicare and/or Medicaid; or (2) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item payable by Medicare and/or Medicaid.

(b) The offering or paying of any remuneration to any person to induce such person: (1) to refer an individual for the furnishing or arranging for the furnishing of any item or service payable by Medicare and/or Medicaid; or (2) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item payable by Medicare and/or Medicaid.[15]

The statute defines "remuneration" broadly to encompass giving anything of value, including but not limited to kickbacks, bribes or rebates. Remuneration can be anything that is given to affect (1) a provider's referral decision (*e.g.*, if a medical practice rents space to a clinical lab and charges the clinical lab in excess of fair market value, such excess rental paid by the lab could be deemed a kickback for referrals the medical practice makes to the lab); or (2) a beneficiary's choice to self-refer (*e.g.*, if a medical practice advertises that it provides free transportation to its patients, that action could be deemed an inducement to Medicare beneficiaries to refer themselves to that practice).

Activities that Violate the Federal Anti-kickback Law

Physicians should not engage in any practice that violates the anti-kickback law, including activities such as

- providing free services or items to, or accepting such services or items from, another provider with whom the physician has a referral relationship;
- paying or charging excessive amounts *above* or *below* fair market value to another provider for the provision of equipment, space or personnel services; and
- entering into joint ventures with other providers or facilities for which applicable safe harbors or exceptions under the anti-kickback laws do not apply, or pursuant to which benefits are conferred on one party in a manner that could be interpreted as an inducement to refer.

Examples of prohibited activities might include any of the following: providing administrative services to a hospital or other facility free of charge, accepting office space for free or below fair market value to see private patients from a facility, accepting interest-free loans from a hospital, renting diagnostic equipment from another professional corporation for less than market value or accepting free equipment, supplies or services from a clinical laboratory that are not directly related to the delivery of the lab's services.

> CASE STUDY: A Queens County physician, having emigrated to the United States from South Korea, habitually gave cash, gift certificates and expensive gifts to physicians who referred patients to him. A corollary federal investigation regarding one of the referring physicians inadvertently captured the Queens County physician giving a gift on videotape, and both physicians were arrested. After confirming the doctor's assertions regarding gift-giving as a Korean cultural tradition, the federal authorities agreed to dismiss the criminal charges. However, the physician was required to disclose the names of all the referring physicians who had received remuneration and to initiate a formal corporate integrity plan.

A referral made for a legitimate medical purpose may still violate the statute if made with the additional intent to pay for referrals or to receive a financial benefit by making a referral. For example, in the criminal trial of a physician who was paid a consultation fee whenever he referred a patient to a cardiac diagnostic laboratory, the court held that as long as *one purpose* of the fee was to induce referrals, the physician could be convicted, even though he also provided legitimate cardiac testing interpretation and counseling to the patients whom he referred for laboratory services. The courts have not definitively resolved whether the illicit intent must be the *primary* purpose of the referral or merely one of several existing purposes.

Safe Harbors

Recognizing that many business relationships are necessary and appropriate for providing quality care to patients, the statute and regulations contain several "safe harbors," each of which has numerous and fairly complex requirements. Merely because an arrangement does not fit within a safe harbor does not mean that it violates the statute. Rather, since the anti-kickback law is a criminal statute, a violation requires proof beyond a reasonable doubt that the parties had unlawful intent. The safe harbors include but are not limited to:

- investment interests
- space rental

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CONTINUED FROM PAGE 10

- equipment rental
- personal service and management contracts
- sale of a practitioner's practice
- referral services
- warranties
- discounts that are properly disclosed and set forth in the claim for reimbursement
- payments made to bona fide employees
- payment by a vendor of goods or services to a group purchasing organization
- waiver of beneficiary coinsurance and deductible amounts
- practitioner recruitment
- obstetrical malpractice insurance subsidies
- investments in group practices
- ambulatory surgical centers
- referral agreements for specialty services[16]

If an arrangement complies with a safe harbor, then such an arrangement is presumptively deemed not to violate the statute. The fact that a financial transaction does *not* fall within one of the safe harbors, however, does not render the transaction automatically illegal. The health care provider who engaged in the transaction (and *not* the government) will have the burden of showing that the transaction or remuneration was *not* a kickback or bribe knowingly received in exchange for a referral or purchase.

The definition of "referral" is very broad and includes actions a physician may not typically consider as referrals.

Penalties

Violation of the anti-kickback law is a felony punishable by a $25,000 fine and up to five years' imprisonment. Further, any person or entity that violates the statute may be excluded from participation in Medicare or Medicaid.[17] Whether or not criminal penalties are imposed, practitioners who violate the statute face exclusion from the federal health care programs. Moreover, any form of discipline imposed under a federal health program must be reported to the National Practitioner Data Bank and thereafter may be the basis of an inquiry and potential discipline by each of a practitioner's respective state licensing authorities.

State

The state of New York has wide-reaching anti-kickback and anti-referral laws and regulations which seek to reduce, and potentially eliminate, fraud and abuse in health care on a statewide level. The state anti-kickback statute is set forth in the Social Services Law.[18] The state Education Law[19] addresses professional misconduct.

The state anti-kickback law provides that any "medical assistance provider" who furnishes services under Medicaid may not solicit or receive any payment or other consideration for the referral of services for which Medicaid payments are made. Any activity covered by exemptions or safe harbors under the federal anti-kickback laws and regulations are specifically exempted from the statute's reach. Violation of the statute is a misdemeanor and subject to possible double damages. However, if the provider obtains money in excess of $7,500 from a violation of the statute, he or she may be guilty of a class E felony, which could result in up to four years in prison.[20] Also, any practitioner who violates the state anti-kickback statute must be reported to the National Practitioner Data Bank.

Professional misconduct is defined to include "[d]irectly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or in connection with the performance of professional services."[21] The state board for professional medical conduct may impose various penalties for such misconduct, including censure and reprimand; suspension of license, wholly or partially; limitation of the license to a specified area or type of practice; revocation of license; annulment of license or registration; limitation on registration or issuance of any further license; a fine not to exceed $10,000 for each charge of misconduct; a requirement that a licensee pursue a course of education or training; and a requirement that a licensee perform up to 500 hours of public service in a manner and at a time and place as the board directs.[22]

PHYSICIAN SELF-REFERRAL PROHIBITION: THE STARK LAWS

Federal

The federal physician self-referral laws (more commonly called "Stark I" or "Stark II" after Congressman Pete Stark who sponsored them) generally prohibit physicians from referring patients to entities for the provision of certain specified health services or items (known as "designated health services," listed below), which are reimbursable by Medicare, if the physicians or their immediate family members have a financial relationship with such entities. Furthermore, the law prohibits entities from receiving such referrals by billing for any such items or services provided.[23]

Prior to 1995, the law applied only to referrals to clinical laboratories ("Stark I"). Amendments to the law ("Stark II") resulted in its expansion to include referrals for services provided in other settings.

For purposes of the Stark law, a financial relationship is defined as a direct or indirect ownership/investment interest or compensation arrangement.[24] "Immediate family members" include the following: spouse, birth or adoptive child, sibling, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, grandparent's spouse and grandchild's spouse.[25] A referral is a request by a physician for an item or service for which payment may be made under Medicare Part B including a request for a consultation (including any tests or procedures ordered or performed by the consulting physician or under the supervision of the consulting physician). In addition, "referral" includes the request or establishment of a plan of care by a physician that includes the furnishing of Designated Health Services with certain exceptions for consultations by pathologists, diagnostic radiology and radiation oncologists.[26]

The definition of "referral" is very broad and includes actions a physician may not typically consider as referrals. For example, an attending physician at a nursing home who orders physical therapy as part of a resident's overall plan of care may not consider his or her order a referral; however, if the physical therapy is reimbursable by Medicare Part B, then the physician has made a referral for the purposes of Stark II.

Unlike the anti-kickback law—a criminal statute under which violations are punishable by fines and imprisonment—no guilty mental state is required for a violation of the Stark laws; they are essentially strict liability provisions under which the very *act of making a prohibited referral is illegal*, and the service rendered cannot be billed to Medicare. Thus, although both the anti-kickback and Stark laws are directed at the same problem of health care providers acting out of financial self-interest, they have different requirements, and one can violate Stark without violating the anti-kickback law, or vice versa.

On January 4, 2001, the Centers for Medicare and Medicaid Services (CMS),[27] in the first of two phases, issued final regulations governing the physician self-referral law. The Phase One regulations became effective January 4, 2002, and address the self-referral prohibitions and exceptions thereto. Phase Two will address, among other things, the reporting requirements, owner-

ship relationship exceptions and the application of the law to Medicaid.

Designated Health Services

The designated health services (DHS) under the Stark law are

- clinical laboratory services;
- physical therapy services;
- occupational therapy services;
- speech-language pathology services;
- radiology services, including MRI, computerized axial tomography (CAT) scans and ultrasound services;
- radiation therapy services and supplies;
- durable medical equipment and supplies;
- parenteral and enteral nutrients, equipment and supplies;
- prosthetics, orthotics and prosthetic devices and supplies;
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.[28]

Exceptions

Stark II provides several exceptions for certain financial arrangements, which can be categorized as follows: (1) exceptions applicable to ownership interests and compensation arrangements; (2) exceptions applicable only to compensation arrangements; and (3) exceptions applicable only to ownership interests.

The exceptions applicable to ownership interests and compensation arrangements are

- physician services;
- in-office ancillary services;
- services furnished by an organization (or its contractors or subcontractors) to enrollees;
- clinical laboratory services furnished in an ambulatory surgical center or end-stage renal disease (ESRD) facility or by a hospice if payment for the service is included in a preset rate;
- services performed by an academic medical center;
- implants in an ambulatory surgical center;
- erythropoietin (EPO) and other dialysis-related outpatient prescription drugs furnished in or by an ESRD facility;
- preventive screening tests, immunizations and vaccines; and
- eyeglasses and contact lenses following cataract surgery.[29]

The exceptions applicable only to compensation arrangements are

- rental of office space;
- rental of equipment;
- bona fide employment relationship;
- personal service arrangements;
- physician recruitment;
- isolated transactions;
- arrangements with hospitals;
- group practice arrangements with a hospital;
- payments by a physician;
- nonmonetary compensation up to a monetary equivalent of $300 per year;
- fair-market-value compensation;
- medical staff incidental benefits;
- risk-sharing arrangements;
- compliance training; and
- indirect compensation arrangements.[30]

The exceptions applicable only to ownership interests are publicly traded securities, mutual funds and an ownership or investment interest in specified entities.[31]

All the above exceptions include specific criteria that must be met. Many of the exceptions require written, signed agreements between the parties which set the terms of the arrangement in advance, are consistent with fair market value and do not take into account the volume or value of any referrals or other business generated between the parties. Unlike the federal anti-kickback law, which allows for the possibility of other exceptions not listed in the statute, arrangements subject to Stark II must fall squarely within one of the above exceptions to avoid violating the statute.

The Stark law is implicated whenever a physician has a financial relationship of any kind with an entity to which the physician refers Medicare business. For example, if a clinical laboratory leases space in a physician's office for a drawing station, the lease constitutes a "compensation arrangement," and the physician cannot refer Medicare or Medicaid testing to the laboratory unless the requirements of one of the exceptions described above are met. Similarly, a compensation arrangement will exist if a physician leases equipment from a laboratory. Again, the physician cannot refer Medicare or Medicaid testing to the laboratory unless the requirements of an exception are met. Transactions often referred to as "table time" deals, in which group practices lease either mobile or free-standing facilities (*e.g.*, MRI or CT offices) on an intermittent or as-needed basis, are not permitted under Stark II. These arrangements no longer meet the requirements of the in-office ancillary service exception.

Penalties

Although Stark II is not a criminal statute, it does carry severe penalties. Violations of Stark II can result in exclusion from Medicare and Medicaid and civil monetary penalties of up to $15,000 for each bill presented for a designated health service in violation of the statute, as

well as an assessment of not more than three times the amount claimed for each item or service.[32]

State

Similar in many respects to its federal counterpart, the state Stark law[33] restricts health care practitioners from making referrals for certain designated health services to entities with which they have a financial relationship. On December 26, 2001, the DOH issued final regulations regarding the state Stark law in an attempt to "bring State regulation into compliance with Federal rules"[34] in this area. Certain material differences remain, however, which can lead to some uncertainty or questions when structuring relationships among health care providers. Some of the more important differences that remain between the state and federal laws include different definitions of which practitioners and payers are covered, what constitutes a designated health service and exceptions to the law.

Although federal laws oblige providers to report and return overpayments, they don't provide a specific time frame for doing so.

The federal law prohibits certain referrals by *physicians*, which is defined to include doctors of medicine or osteopathy legally authorized to practice medicine and surgery, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry and chiropractors. The state law, on the other hand, prohibits referrals by *practitioners*, which encompasses all individuals covered by the federal prohibition but also includes nurses, midwives, physician's assistants or special assistants and physical therapists.

The federal law covers only those referrals for which the services will be reimbursed by Medicare or Medicaid. The state law is far more expansive and covers all referrals of DHS, regardless of payer class. Thus, not only are Medicare and Medicaid included but all private insurance and managed care plans as well as self-pay patients. In addition, the state law provides private insurance companies a right to sue, which does not exist for private parties under the federal law.

Although both the federal and state Stark laws limit the ability to refer DHS, the federal law generally (but not in all instances) includes a more expansive list of prohibited DHS. The state DHS include only the following: clinical laboratory services, pharmacy services, radiation therapy services or X-ray or imaging services. Effective December 8, 2002, physical therapy services will also be included.

In addition, the federal and state laws define DHS differently. The federal law defines certain categories of DHS (such as X-ray and imaging services) by the applicable Medicare CPT/HCPCS code. Various invasive procedures, as well as nuclear medicine procedures, are expressly excluded from the federal DHS list. The state regulations provide a broader definition of these services. For example, the state law defines X-ray or imaging services as "diagnostic imaging techniques," which include the following: conventional X-ray or radiology, fluoroscopy, digital radiography, computed tomography, magnetic resonance imaging, nuclear imaging, ultrasonography and angiography.[35] Certain of these eight diagnostic services are not included in the federal law.[36]

Generally, the federal law contains exceptions that do not appear in the state counterpart. These include, among others, exceptions for services provided by academic medical centers, nonmonetary compensation with a monetary equivalent up to $300, fair-market-value compensation arrangements, incidental medical staff benefits provided by a hospital to its medical staff, compliance training provided by a hospital to a physician and indirect compensation agreements. In addition, as a result of changes in the federal Phase One regulations, certain of the federal exceptions are now narrower than their state counterparts.

VOLUNTARY REFUNDS

Medicare Overpayments

Under federal laws and regulations, once a physician practice determines that it has received an overpayment of Medicare funds, the amount so determined is a debt owed to the U.S. government. Generally, a physician practice will disclose information to the government regarding overpayments received in accordance with one of the following scenarios:

- If an overpayment or error has occurred that *does not involve a violation* of the law, the physician practice should report and refund the overpayment to the carrier, as detailed below.
- If the overpayment resulted from some practice that *potentially violated* federal criminal, civil or administrative laws, the physician practice should follow the OIG's provider self-disclosure protocols, which are discussed below.

Overpayments that Do Not Violate the Law

Examples of simple overpayments include payment based on a charge that exceeds the reasonable charge; duplicate processing of charges/claims; payment on a nonassigned claim; payment for noncovered items and services, including medically unnecessary services; in-

correct application of the deductible or coinsurance; payment for items or services rendered during a period of nonentitlement; primary payment for items or services for which another entity is the primary payer; and payment for items or services rendered after the beneficiary's date of death.

Although federal laws oblige providers to report and return overpayments, they don't provide a specific time frame for doing so. However, federal statutes make it a crime for a provider to conceal or fail to disclose events affecting the right to receive payment or benefits from a federal health care program with an intent to fraudulently secure such benefit or payment. Thus, CMS has stated that, in certain circumstances, a provider's failure to notify a carrier of an overpayment "within a reasonable period of time" is possibly indicative of criminal liability worthy of referral to the OIG for investigation. As to what constitutes a reasonable time frame, CMS has proposed a rule that would require providers who discover they have received a Medicare overpayment to report and return the overpayment to the appropriate carrier within 60 days of identifying the overpayment.

When a health care provider discovers that it has received an overpayment from Empire Medicare Services and when the overpayment *does not* imply any violation of law, the provider must submit an overpayment refund form to the carrier.[37] The form requires that all individual claims for which a refund is being made be identified in detail. It also allows for a refund based on "statistical sampling." In such instances, however, the methodology and formula used to determine the amount of overpayment must be explained. If the health care provider is subject to a corporate integrity agreement, it must so indicate on the overpayment refund form.

GHI Medicare does not require a similar form to accompany refunds of overpayments. Refunds to GHI Medicare should include a copy of the remittance, a copy of the claim and a cover letter and should be submitted to GHI Medicare, P.O. Box 2870, New York, NY 10116-2870, Attn: Accounting Department.

A carrier or intermediary must report to the OIG if an unsolicited refund raises a "strong suspicion of fraud" or if the provider is under "active investigation."

Overpayments Resulting from Practices that Potentially Violate the Law

Health care providers should follow the OIG's self-disclosure protocols when they have done an initial assessment and reasonably believe that some practice potentially violates federal criminal, civil or administrative laws. Although the introduction to the self-disclosure protocols states that providers have a "legal duty to ensure the integrity of their dealings with these programs" (referring to federally funded health care programs), providers do not have a "legal duty" to follow these protocols.

However, health care providers can benefit from self-disclosure in the following ways: (1) possibility of minimizing the potential cost and disruption associated with a full-scale audit and investigation; (2) opportunity to negotiate a fair monetary settlement; and (3) opportunity to avoid exclusion from participating in federal health care programs. On the other hand, self-disclosure carries some risk insofar as the OIG makes no commitment as to how a disclosure will be resolved or what benefit the disclosing provider will achieve by the voluntary disclosure. In other words, the OIG is not bound by any of the disclosing provider's findings, and it may conclude that the matter warrants a referral to the Department of Justice.

The OIG's disclosure process has several mandated components. First, the provider must submit to OIG's assistant inspector general for investigative operations an initial detailed description of the matter being disclosed. Second, the provider must undertake a comprehensive internal investigation to determine how the inappropriate practice was discovered. The investigative report submitted to the OIG must fully describe the investigation and the corrective action instituted to prevent future abuses. Third, the health care provider must submit a work plan to the OIG describing how it will conduct a financial self-assessment to estimate the monetary impact of the disclosed practice on the federally funded health care program. Finally, the provider must submit a detailed report of the financial investigation.

Once the OIG receives the self-disclosure documents, it will begin its verification process. The breadth of its review depends upon "the quality and thoroughness of the internal investigative and self-assessment reports."[38] The OIG will consider any lack of cooperation by the disclosing provider an aggravating factor when determining the final resolution of the matter, and any new issue identified during a self-disclosure review will be treated as a separate matter outside the voluntary disclosure protocol.

Medicaid Overpayments

Physicians must report Medicaid overpayments to the DOH. Under the DOH's rules and regulations, an "unacceptable practice" is conduct that constitutes fraud or abuse. It includes, among other things, a failure to disclose, which is defined as "having knowledge of any event affecting the right to payment of any person and concealing or failing to disclose the event with the intention that a payment be made when not authorized or in a greater amount than due."[39]

Engaging in an unacceptable practice, as defined above, may subject a health care provider to (1) exclusion from the Medicaid program for a reasonable time; (2) censure; (3) conditional or limited participation in the program, such as requiring pre-audit or prior authorization of claims for all medical care, services or supplies; and (4) repayment of overpayments. However, once the DOH determines that a physician has engaged in an unacceptable practice, its authority to impose sanctions is discretionary. The regulations[40] require the DOH to consider the following: (1) the number and nature of the violations; (2) the nature and extent of any adverse impact; (3) the amount of damages to the program; (4) any mitigating circumstances; (5) other facts related to the nature and seriousness of the violations; and (6) the previous record of the person under the Medicare and Medicaid programs.

Private Insurer Overpayments

Physician practices must disclose overpayments to private insurers. Several criminal statutes, both federal and state, may apply to situations in which health care providers fail to make such disclosures. For example:

• ***Theft or embezzlement in connection with health care*** To knowingly embezzle, steal, convert or intentionally misapply any of the monies, funds, securities, premiums, credits, property or other assets of a health care benefit program is a federal crime. Penalties include fines and/or imprisonment of up to ten years.[41]

• ***Health care fraud*** To knowingly and willfully execute, or attempt to execute, a scheme either to defraud a health care benefits program or to obtain, by means of false representations or pretenses, any money or property owned or controlled by a health care benefits program is a crime. Penalties include fines and 10 years in prison, 20 years in prison if the violation results in serious bodily injury and life imprisonment if the violation results in someone's death.[42]

• ***Insurance fraud*** To submit a claim to an insurer for payment with the intent to defraud the insurer, knowing that the claim either contains materially false information or conceals information concerning a material fact, is a crime under New York State law. Penalties can range from six months to 25 years in jail.[43]

• ***Larceny prosecutions*** Under New York State law, a person commits larceny when, with intent to deprive another of property or to appropriate the same to himself or to a third person, a person wrongfully takes, obtains or *withholds* such property from an owner thereof.[44] A wrongful taking, obtaining or *withholding* of another's property includes an acquisition of lost property, which is defined as when a person "exercises control over property of another which he knows to have been lost or mislaid or to have been *delivered under a mistake* as to the identity of the recipient or to the nature *or amount of the property, without taking reasonable measures to return such property to the owner*."[45] The value of the property will determine the class of crime. Penalties can range from fines and short-term imprisonment up to 25 years in jail.

COMPLIANCE PROGRAMS

As part of its initiative to combat health care fraud and abuse, the OIG has issued compliance guidance for several sectors of the health care industry, including hospitals, home health agencies, clinical laboratories, medical billing companies, durable medical equipment companies, hospices and nursing facilities. The latest set of compliance program guidelines focuses on individual and small physician practices. In keeping with the recommendations in its other guidelines, the OIG suggests that effective compliance programs for physician practices contain the following seven components: (1) internal monitoring and auditing; (2) implementation of compliance and practice standards; (3) designation of a compliance officer or contact; (4) training and education; (5) appropriate responses to and corrective action regarding detected offenses; (6) open lines of communication; and (7) enforcement of disciplinary standards through well-publicized guidelines.

A compliance program should not only prevent improper conduct, whether intentional or not, from occurring, but also detect and prevent *patterns* of improper conduct or the appearance of such improper patterns from developing. At the very least, a compliance program must *educate* all personnel concerning applicable laws, rules and regulations, *detect* problematic practices and *react* to violations, and it must do so in a manner that will satisfy the concerns and requirements of governmental guidelines for effective compliance programs.

The most important issues for a physician practice's compliance program involve documentation, coding and billing, including billing procedures; the use and design of charge tickets; credit balances; the use of uniform provider identification numbers (UPINs); "incident to" billing; professional courtesy practices; tracking of Medicare bulletins; and waiver of copayment practices. In addition, a compliance program should address the physician practice's compliance with the anti-kickback and Stark laws, focusing on the practice's relationship with other health care providers, its referral and related business practices and its existing or proposed contractual agreements.

Implementing a compliance program is purely voluntary, but doing so has certain benefits. Although the existence of a compliance program is no guarantee that the government will not investigate or find a physician

practice or its employees liable for some violation, having such a program can significantly reduce potential exposure. For example, federal and state regulators have broad discretion in determining—especially in overpayment situations—whether to assess penalties or, ultimately, to exclude a provider from participation in entitlement programs. A physician practice with an active compliance program is in a much better position to argue against the imposition of these discretionary fines and penalties. In addition, if government agents do begin investigating, the existence of a compliance program will go a long way toward reducing the extent of their investigation. The program demonstrates not only the physician practice's good faith but, more importantly, that it took affirmative steps to comply with the law. This showing can then help convince the government that the violation is an aberration, as opposed to a routine and ongoing business practice. It may also reduce the scope of an investigation, allowing the government to rely to some extent on the compliance audits and reviews.

In short, the existence of an effective compliance plan provides evidence that any improper behavior uncovered was inadvertent and unintentional. As such, the existence of such a plan is a significant factor to be considered in ascertaining whether a physician practice has made reasonable efforts to avoid and detect fraudulent behavior. Such a finding is relevant when determining the level of sanctions, penalties and exclusions that the government will seek to impose on the health care provider. Indeed, as more and more providers implement compliance programs, the physician practice without a program will find it increasingly difficult to assert that it is taking all reasonable steps to obey the law.

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1. 31 U.S.C. §§ 3729–3733.
2. The government must meet its burden of proof by a preponderance of the evidence for all elements, including damages. 31 U.S.C. § 3731(c).
3. 31 U.S.C. § 3729(b); *see* Willens, U.S.C. Commentary, 31 U.S.C. § 3729(b).
4. 31 U.S.C. § 3729(b).
5. Memorandum from Eric H. Holder, Jr., Deputy Attorney General, to All United States Attorneys, All First Assistant United States Attorneys, All Civil Health Care Fraud Coordinators in the Offices of United States Attorneys, and All Trial Attorneys in the Civil Division Commercial Litigation Section, Guidance on the Use of the False Claims Act in Civil Health Care Matters (dated June 3, 1998) available at <http:www.//usdoj.gov/04foia/readingrooms/chcm.htm>.
6. 31 U.S.C. § 3729(a)(2); *see* Willens, U.S.C. Commentary, 31 U.S.C. § 3729(a)(1), (2).
7. 42 U.S.C. § 1320a-7b(a).
8. 31 U.S.C. § 3729(a)(3).
9. 18 U.S.C. § 1341.
10. 18 U.S.C. § 1343.
11. *See* Willens, U.S.C. Commentary, 31 U.S.C. § 3729 (penalties).
12. 42 U.S.C. § 1320a-7b(a).
13. 18 U.S.C. § 1518.
14. 18 U.S.C. §§ 669, 1035, 1347, 1518.
15. 42 U.S.C. § 1320a-7b(b).
16. 42 C.F.R. § 1001.952.
17. 42 U.S.C. § 1320a-7b(b).
18. *See* N.Y. Social Services Law § 366-d (SSL).
19. *See* N.Y. Education Law § 6530 ("Educ. Law").
20. *See* SSL § 366-d; N.Y. Penal Law § 70.00.
21. Educ. Law § 6530(18).
22. N.Y. Public Health Law § 230-a ("Pub. Health Law").
23. 42 C.F.R. §§ 411.350(a), 411.353(b).
24. 42 C.F.R. § 411.354(a)(1)(i)–(ii).
25. 42 C.F.R. § 411.351.
26. *Id*.
27. Formerly known as the Health Care Financing Administration (HCFA).
28. 42 C.F.R. § 411.351.
29. 42 C.F.R. § 411.355.
30. 42 C.F.R. § 411.357.
31. 42 C.F.R. § 411.356.
32. 42 U.S.C. § 1395nn(g)(3).
33. Pub. Health Law § 238.
34. 2001-52 N.Y. St. Reg. 7 (Dec. 26, 2001).
35. 10 N.Y.C.R.R. § 34-1.2.
36. *See* 42 C.F.R. § 411.351.
37. Empire Medicare Services' Overpayment Refund Form was published in the Medicare News Brief, 99-5 and is available through its Web site at <www.empiremedicare.com>.
38. Publication of the OIG's Provider Self-Disclosure Protocol, 63 Fed. Reg. 58,399.
39. N.Y. Comp. Codes, R. & Regs. tit. 18, § 515.2(b)(3) (N.Y.C.R.R.).
40. 18 N.Y.C.R.R. § 515.4.
41. 18 U.S.C. § 669.
42. 18 U.S.C. § 1347.
43. Penal Law § 176.05.
44. Penal Law § 155.05 (emphasis added).
45. *Id*. (emphasis added).

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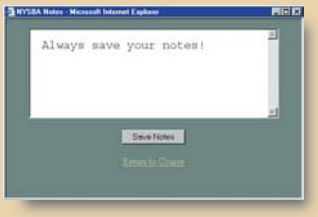

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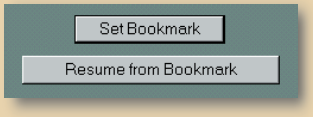

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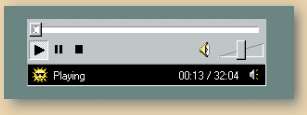

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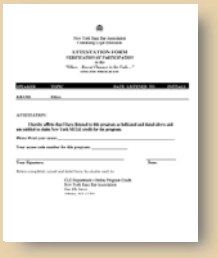

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A Review of Uninsured Motorist And Supplementary Uninsured Motorist Cases Decided in 2001

By Jonathan A. Dachs

As eight previous articles on this topic attest,[1] the area of uninsured (UM) and underinsured motorist (UIM) insurance law is ever-changing and the subject of a great deal of litigation. Indeed, one Supreme Court justice assigned specifically to handle UM and UIM cases recently noted that "as anyone familiar with the uninsured area of the law is acutely aware, things are not always what they appear on their face."[2]

GENERAL ISSUES

Conflicts of Law

Where there is a conflict of law relating to an insurance policy, the conflict must be resolved by application of the conflict of law rules relevant to contracts.[3] The courts apply the "center of gravity" or "grouping of contacts" inquiry, and consider such significant contacts as the place of contracting, the place of negotiation and performance, the location of the subject matter of the contract, and the domicile or place of business of the contracting parties.[4] Thus, where the offending vehicle was driven by a Rhode Island resident, with a Rhode Island driver's license, and a car registered in Rhode Island was insured by a Rhode Island insurer through a policy issued in Rhode Island, which provided for application of Rhode Island law, and New York was merely the situs of the accident and the domicile of the other parties to the accident, the law of Rhode Island was held to govern the propriety of the insurer's notice of cancellation where that law (requiring a minimum of 10 days' notice for a cancellation based upon nonpayment of premiums) conflicted with New York's law (requiring a minimum of 15 days' notice).[5]

Self-Insurance

In *Gallagher Bassett Services, Inc. v. Makerevich*,[6] the court held that a self-insured automobile rental company is obligated to provide primary UM coverage to the renters/lessees of its vehicles.

In *Elrac, Inc. v. Ward*,[7] the Court of Appeals held that a rental car company is subject to the minimum liability insurance requirements even though it is self-insured and, therefore, may not seek indemnification from the renter for any injuries caused to third parties by the use of the rental car, where the damage falls below the minimum insurance the rental company is required to provide under N.Y. Vehicle and Traffic Law § 370(1) (VTL).[8]

"Use or Operation"/Accidents

The UM/supplementary uninsured motorists (SUM) endorsements provide for benefits to "insured persons" who sustain injury caused by "accidents" "arising out of the ownership, maintenance or use" of an uninsured motor vehicle.

In *Progressive Northwestern Ins. Co. v. Van Dina*,[9] claimant was in a parking lot, placing packages into the trunk of her car, when an unidentified vehicle drove past and its driver reached out and grabbed her purse. Claimant was pulled alongside the accelerating vehicle and eventually thrown to the ground and injured. The court held that claimant's injuries were the result of an intentional act and not the result of an accident. It denied the claim for uninsured motorist benefits and permanently stayed the arbitration demanded by claimant.

In *Cohn v. Nationwide Mutual Ins. Co.*,[10] the defendants were passengers in a taxicab owned by defendant taxi company and insured by American Transit Insurance Co. The plaintiff was allegedly injured while riding a bicycle when the defendants opened the taxi door directly into her path and struck her. The Second Department

Jonathan A. Dachs, a member of the firm of Shayne, Dachs, Stanisci, Corker & Sauer in Mineola is the author of "Uninsured and Underinsured Motorist Protection" 4 *New York Insurance Law*, Chapter 51 (Matthew Bender & Co., Inc.), and of a chapter on UM/UIM and SUM (Pre- and Post-Regulation 35-D), in *Weitz on Automobile Litigation: The No-Fault Handbook* (New York State Trial Lawyers Institute). He is a graduate of Columbia University and received his J.D. degree from New York University Law School.

upheld the lower court's order that American Transit was not required to defend the passengers in connection with the plaintiff's personal injury action, but held that plaintiff's cross-motion for a declaration that American Transit was required to provide liability insurance to its insureds pursuant to VTL § 388 for any injuries caused by the taxi as a result of its use by passengers should have been granted. "The passengers' act of opening the taxicab door in order to exit the vehicle constitutes 'use and operation' of a vehicle pursuant to Vehicle and Traffic Law § 388."

Timely Notice of Claim

UM, UIM and SUM endorsements require the claimant, as a condition precedent to the right to apply for benefits, to give timely notice to the insurer of an intention to make a claim. Although the new mandatory UM endorsement requires such notice to be given "within ninety days or as soon as practicable," Regulation 35-D's SUM endorsement requires simply that notice be given "as soon as practicable." A failure to satisfy the notice requirement vitiates the policy and the insurer need not demonstrate any prejudice before it can assert the defense of noncompliance with the notice provisions. The interpretation of the phrase "as soon as practicable" was a hot topic in 2001.

In *Travelers Indemnity Co. v. Worthy*,[11] the court reiterated the well-established rule that where the policy requires the claimant/insured to give notice of claim to the SUM insurer "as soon as practicable," that notice must be given "within a reasonable time under all the circumstances." Where there is a substantial delay in giving such notice, the claimant/insured is obliged to demonstrate that he or she "acted with 'due diligence' in ascertaining the insurance status of the vehicle involved in the collision."[12]

Following the Court of Appeals' 1999 decision in *Metropolitan Property & Casualty Ins. Co. v. Mancuso*,[13] which held that in the context of an underinsured motorist claim, the phrase "as soon as practicable" means "with reasonable promptness after the insured knew or should have known that the tortfeasor was underinsured," several courts have addressed the issue of timely notice. In *Allstate Ins. Co. v. Earl*,[14] and *Continental Ins. Co. v. Boyar*,[15] the courts reiterated this standard.

In *New York Central Mutual Fire Ins. Co. v. Moore*,[16] the court held that a 42-month delay in giving notice was unreasonable because claimant failed to meet her burden of establishing a reasonable excuse for the delay, the nature and extent of the injury did not change, she did not demonstrate due diligence in determining the insurance status of the tortfeasor, she was aware of the identity of the tortfeasor, and she was represented by counsel during most of the 42-month delay.

In *Nationwide Ins. Co. v. Bellreng*,[17] the court held that the insured provided notice of an SUM claim "as soon as practicable" where his initial X-rays were "unremarkable" and he did not learn until five months later that he sustained a torn rotator cuff. Written notice was provided 17 days after receipt of a report indicating that the injury was "more significant than originally determined."

In *Eagle Ins. Co. v. Garcia*,[18] claimants proffered as an excuse for their late notice of claim that they were misled by the insurance code in the police accident report, which indicated a different insurer as *their* carrier. The court rejected that excuse, noting, "An insured's ignorance of his or her insurance carrier constitutes gross negligence and is not a valid excuse for the failure to provide the carrier with timely notice."

In *Allstate Ins. Co. v. Earl*[19] and *Metropolitan Property & Casualty v. Pacheco*,[20] the courts noted that the fact that the SUM carrier had potential knowledge of the SUM claim because it was the claimant's no-fault carrier, does not alter the fact that the claimant failed to provide timely written notice of an SUM claim. Actual notice of the accident by other means does not vitiate the requirement that the claimant provide timely notice. The fact that the petitioner insurer may have received some notice of the accident through the claimant's no-fault claim "does not vitiate the breach of a policy requirement" for timely notice of an SUM claim.[21]

In *Hazen v. Otsego Mutual Fire Ins. Co.*,[22] the injured party effectively "saved the day" by giving the liability insurer notice of the accident when the insured had failed to do so. Even though the notice by the injured party was itself untimely, because the insurer's disclaimer was premised upon the insured's failure to give notice of the accident and made no reference to the injured party's late notice, the court held that the disclaimer was invalid as against the injured party, who was then entitled to summary judgment in her direct action against the insurer to recover on the judgment she obtained by default against the insured.[23]

In *Bennion v. Allstate Ins. Co.*,[24] the court reiterated the rule that notice to an insurance broker does not demonstrate notice to the insurer because a broker is deemed to be the agent of the insured, and not of the insurer. The court further noted that to establish that a broker was acting as the insurer's agent, "there must be evidence of some action on the insurer's part, or facts from which a general authority to represent the insurer may be inferred." In that case, plaintiff submitted evidence that Allstate had informed its insured that he should "[c]ontact [his] agent, broker or producer of record if [he had] any questions about [his] insurance coverage," thereby raising a triable issue of fact as to whether Allstate held the broker out as its agent.

Finally, the notice letter to the insurer should be specific and definite. In *Metropolitan Property & Casualty v. Pacheco*,[25] claimant's attorney sent the SUM carrier a letter stating, "'Since the vehicle which struck your insured's vehicle may have carried no liability insurance at the time of the accident, we hereby make claim under the uninsured provisions of your insured's policy and make claim for any underinsured coverage that may exist.'" The court held that the letter did not serve as a Notice of Claim because

> it merely indicated a potential claim for underinsurance benefits, a potential which in theory exists in most automobile accidents. . . . The letter . . . clearly indicates that [claimant's counsel] has not yet determined the amount of the tort feasor's liability insurance, nor is there any indication in the . . . papers as to the extent of [claimant's] injuries, or the time frame in which the seriousness of his injuries was discovered. . . . [The] letter . . . gives the insurer no more information than it had before it received the letter.[26]

Notice of Legal Action

In addition to the basic notice requirement, the UM and SUM endorsements also require, as a condition precedent to coverage, that the insured or his or her legal representative "immediately" forward to the insurer a copy of the summons and complaint and/or other legal papers served in connection with the underlying lawsuit against the tortfeasor.[27]

In *Fisher v. Hanover Ins. Co.*,[28] a case involving liability insurance and the requirement in a liability policy to immediately forward copies of the summons and complaint served *upon* the insured, the court held that although the insurer might have had notice of the accident and claim against the insured through settlement discussions, neither those discussions nor a letter to the insurer alleging that service had been made against the insured was sufficient to cure the insured's breach of the policy provision requiring prompt forwarding of the legal papers.

Several courts in 2001 noted, however, that the breach of the Notice of Legal Action provision is one that requires a timely notice of disclaimer. If the insurer's disclaimer is untimely, it will be precluded from relying upon the claimant's failure to provide Notice of Legal Action to deny a claim.[29]

NOTE: In a decision handed down April 30, 2002, in *Brandon v. Nationwide Mutual Ins. Co.*,[30] the Court of Appeals held that an insurer intending to rely upon the breach of the Notice of Legal Action condition of the policy must demonstrate that it has been prejudiced by that breach. This decision creates a new rule for Notice of Legal Action cases which is in contradistinction to the "no prejudice" rule applicable to other types of notice.

Discovery

The UM and SUM endorsements also contain provisions requiring, upon request, a statement under oath, examination under oath, physical examinations, authorizations and medical reports and records. The provision of each type of discovery, if requested, is a condition precedent to recovery.

In *Allstate Ins. Co. v. Miles*,[31] the court held that because the petitioner had ample time before the commencement of the proceeding within which to seek discovery of the respondent insured as provided for in the insurance policy, and unjustifiably failed to utilize that opportunity, the insurer had waived the right to the discovery it sought.

On the other hand, in *Lancer Ins. Co. v. Berman*,[32] *Allstate Ins. Co. v. Moya*,[33] and *State Farm Mutual Automobile Ins. Co. v. Johnson*,[34] the courts allowed the SUM carrier to proceed with the discovery it sought under the policy, *i.e.*, medical authorizations, discovery of medical records and reports, depositions and physical examinations in aid of arbitration.

Petitions to Stay Arbitration

Venue Effective August 16, 2000, the venue rules of N.Y. Civil Practice Law & Rules 7502 were substantially changed.[35]

In *Allstate Ins. Co. v. Timmer*,[36] and hundreds of similar decisions issued by the Supreme Court in Nassau County in cases where the venue of a petition to stay arbitration was brought in Nassau County, after the amendment to CPLR 7502, solely because the petitioner did business there, but the claimant/respondent did not reside there, the court denied the petition and granted judgment in favor of the respondents, dismissing the petition "without prejudice to the filing of a new petition in a proper county" within 20 days after entry of the order. The court noted the exceedingly large volume of such petitions filed in Nassau County and the severe drain that such cases had put on the court's resources. The court also noted that 85% to 90% of the respondents in these cases did not reside in Nassau County. The court took offense at the petitioners' attempts to ignore and/or circumvent the provisions of the new statute, and rejected the insurer's reliance upon the venue provisions of CPLR 509. Finally, the court even threatened to impose sanctions if the insurers' practice of bringing petitions in an improper venue continued.

However, in *Travelers Indemnity Co. of Illinois v. Uchenna Nnamani*,[37] the Appellate Division, Second Department, reversed a similar (actually verbatim) order, noting that "CPLR 509 and 510 authorize a court to change venue only upon motion or consent. [A] court may not *sua sponte* transfer venue." The court further stated that the CPLR Article 5 procedures for changing

venue are applicable to proceedings to stay arbitration under CPLR 7502, and that consequently, "in the absence of a motion or consent, the court had no authority to *sua sponte* change venue. It could not, in effect, do so by dismissing the petition without prejudice to refiling in the proper county." Finally, the court added that CPLR 7502(a)(i) is a venue provision, which does not affect the jurisdiction of the court. Therefore, there was no jurisdictional basis for dismissal. The Supreme Court's "inherent power to control its calendar does not include the authority to *sua sponte* dismiss an improperly venued proceeding."[38]

However, subsequently, in the remand of *Travelers Indemnity Co. v. Nnamani*,[39] the Supreme Court, interpreting the Appellate Division's decision in that case, held that it was *not* a mandate that the Supreme Court accept and dispose of uninsured motorist proceedings "without reference to the venue." The court chastised those insurers and their attorneys who continued to utilize Nassau County for their petitions where no valid basis for Nassau County venue existed, even after CPLR 7502 was amended, and noted the court's inherent power to control its calendars, which includes "a right to dismiss without prejudice in order to insure that the court's judicial and clerical personnel not be diverted from properly venued matters." Accordingly, the court listed and discussed its various options for what it deemed improperly venued petitions: (1) the imposition of sanctions for the "frivolous" and "completely without merit in law" institution of a non-resident proceeding in Nassau County in cases where respondents-insureds are required to resort to the provisions of CPLR 511 to obtain a change of venue; and (2) the setting up of a special calendar procedure in cases in which counsel for non-resident insureds elect *not* to resort to CPLR 511 to obtain a transfer of venue, whereby "it will be assured that all matters properly venued in this Court will be disposed of before improperly venued matters come on to be heard." Finally, the court advised the "uninsured bar" as follows:

> All proceedings not already submitted in which venue is improper and respondent has raised such issue [will be submitted] . . . for determination and consideration given to the imposition of sanctions in the event a transfer is directed. In those instances where respondent has not challenged the venue, the petitions will be adjourned by the court for a period of 30 days with leave granted to respondent-insured to seek a change of venue by cross-motion. In the event a respondent-insured declines the court's invitation to seek such a change, the proceeding will be assigned to a "non-resident uninsured" calendar to be considered when all properly venued cases have been disposed of.[40]

Several courts in 2001 noted that the breach of the Notice of Legal Action provision is one that requires a timely notice of disclaimer.

Timeliness CPLR 7503(c) provides, in pertinent part, that "[a]n application to stay arbitration must be made by the party served within twenty days after service upon him of the notice [of intention to arbitrate] or demand [for arbitration], or he shall be so precluded." It well-established that the failure to make a timely application to stay arbitration will result in the denial of the application as untimely and constitute a bar to judicial intrusion into the arbitration proceeding. One exception to the 20-day rule is that where the application to stay is based upon the ground that no agreement to arbitrate exists, it may be entertained even if made after the 20-day period has expired.[41]

In *Allstate Indemnity Co. v. Fernandez*,[42] the court held that a claim that "the policy was canceled two weeks prior to the accident for non-payment of premiums 'relates to whether certain conditions of the contract have been complied with and not whether the parties have agreed to arbitrate' . . . and, as such is outside the scope of the exception to CPLR 7503(c)'s 20-day limitation period."

In *Empire Ins. Co. v. Busse*,[43] the court held that the contention that the claimant was not entitled to any underinsured, as opposed to uninsured, benefits under the policy and/or that the maximum amount of such benefits was offset by the amounts received from the tortfeasor's insurer, related to whether certain conditions of the policy had been complied with and not whether the parties agreed to arbitration, and, therefore, the 20-day rule applied.

In *Interboro Mutual Ins. Co. v. Devone*,[44] the Supreme Court held that the issue of whether other vehicles were insured, and, thus, whether coverage exists under the uninsured motorist coverage, was not subject to the 20-day rule; on the other hand, the issue of whether there was physical contact with the offending vehicle involves a condition precedent to coverage rather than the non-existence of coverage, and was subject to the 20-day rule.

Filing and Service In past years, I have advised that when the time to file a Petition to Stay Arbitration is close to expiring, it is not advisable to use an Order to Show Cause instead of a Notice of Petition. This is because it has been held that the filing of an *unsigned* Order to Show Cause is a nullity and does not effectively commence a special proceeding; the requisite fil-

ing does not actually take place until the Order to Show Cause is signed by the judge and then filed, which may be several days after the Order to Show Cause was first presented and filed.[45] In *Grant v. Senkowski*,[46] the Court of Appeals reaffirmed this rule and noted that a filing sufficient to constitute commencement under CPLR 304 occurs when the Clerk receives the papers. Effective November 21, 2001, the commencement statutes were amended to provide that a special proceeding, such as a proceeding to stay arbitration, "is commenced by filing a petition [only]."[47]

NOTE: The legislation amending CPLR 304, 306-a and 306-b did not contain a corresponding amendment to CPLR 203(c)(1). That section still provides, in effect, that the statute of limitations is not tolled until the notice of petition or order to show cause is filed with the petition.[48]

Burden of Proof An insurer seeking to stay arbitration of an uninsured motorist claim has the burden of establishing that the offending vehicle was insured at the time of the accident. Once a *prima facie* case of coverage is established, the burden shifts to the opposing party to come forward with evidence to the contrary.[49]

Where the documents submitted by the parties raise issues of fact regarding whether the offending vehicle was uninsured and/or whether the alleged insurer of the offending vehicle properly disclaimed coverage, a hearing should be held at which the alleged insurer and its insured should be joined as additional respondents.[50]

On the other hand, where the petitioner makes out a *prima facie* case of insurance on the offending vehicle, and no evidence is submitted to raise a triable question on the issue of coverage, no hearing is required and the petition should be granted.[51]

In *GEICO v. McFarland*[52] and *GEICO v. Williams-Staley*,[53] the courts reiterated the well-established rule that the initial burden of proving that the alleged offending vehicle was insured at the time of the accident may be met by the submission of a copy of the police accident report identifying the insurer of that vehicle. In *Williams-Staley*, the court held that the petitioner did not meet its burden of proof because the police report did not identify the offending vehicle's insurer but, rather, simply indicated "N/A" for the insurance code. In *Interboro Mutual Indemnity Ins. Co. v. McBride*,[54] the court noted that the initial burden of proof of insurance could also be met by the submission of DMV records.

In *Lumbermen's Mutual Casualty Co. v. Nespolini*,[55] the court held that where the petitioner identified a number of inconsistencies in respondent's various descriptions of the accident, an issue of fact was raised as to, *inter alia*, whether or not another vehicle made contact with respondent's motorcycle, and, thus, a framed issue hearing was required.

In *New York Central Mutual Fire Ins. Co. v. Rozenberg*,[56] the court held that a bald disclaimer merely creates an issue of fact as to its validity, which should be explored at a hearing, at which the disclaiming insurer is a "necessary party." Similarly, in *Windsor Group v. Hawkins*,[57] the court held that the written statement by the alleged insured that he had canceled his policy prior to the accident did not suffice to overcome the *prima facie* showing of coverage because it was not in admissible form and should not have been considered by the court.

Arbitration Awards

Issues for the Arbitrator In *New York Central Mutual Fire Ins. Co. v. Guarino*,[58] the court held that "[t]he issue of timeliness is for the court, not the arbitrator, to decide."

Scope of Review In *Shomron v. Fuks*,[59] the court stated that "'[p]recisely because arbitration awards are subject to judicial deference, it is imperative that the integrity of the process, as opposed to the correctness of the individual decision, be zealously safeguarded' (*Matter of Goldfinger v. Lisker*, 68 N.Y.2d 225, 230 . . .)."

In *Velez Organization v. J. C. Contracting Corp.*,[60] which dealt with an arbitration conducted by a panel of three arbitrators, one arbitrator was convicted of commercial bribery during the course of the arbitration, and this was not disclosed to the parties. Under these circumstances, the court held that vacatur of the arbitrator's May 30, 2002, award was warranted and remanded the matter for a new hearing before a different panel of arbitrators, noting,

> The nature of the conviction established corruption on the part of the arbitrator in question and placed serious doubt on his ability to act impartially and fairly. Moreover, such conduct tainted the integrity of the arbitration process and created an appearance of impropriety. "Precisely because arbitration awards are subject to such judicial deference, it is imperative that the integrity of the process, as opposed to the correctness of the individual decision, be zealously safeguarded."

In *Jenkins v. Empire/Allcity Ins. Co.*,[61] the court held that an arbitration award "in a mandatory arbitration, such as this one, may be upheld only if it is supported by the evidence and is not arbitrary and capricious."

In *GEICO General Ins. Co. v. Canal Ins. Co.*,[62] the court explained that "totally irrational" conduct requires a showing that there was 'no proof whatever to justify the award.'"

In *Jaidan Industries, Inc. v. M.A. Angeliades, Inc.*,[63] the Court of Appeals noted that "an arbitration award may be vacated on public policy grounds only where it is clear on its face that public policy precludes its enforcement."

Collateral Estoppel In *Searchwell v. L.G.A. Transportation, Inc.*,[64] the court noted that "the doctrines of res ju-

dicata and collateral estoppel are applicable to arbitration proceedings. Thus, the court held that

> where an arbitration award rendered pursuant to an uninsured motorist indorsement in an amount below the statutory maximum is reduced to judgment and satisfied, it must be considered, prima facie, to be the total damages due for noneconomic loss, unless the arbitrator indicates that the award is limited to the damages caused by the uninsured vehicle.[65]

In *Uccio v. Dougan*,[66] the court noted that "the fact that the plaintiff settled an uninsured motorist claim against her insurer regarding the accident at issue does not preclude her from bringing the instant action to recover for the defendant's alleged negligence for the same accident."

Post-Award Proceedings The Court of Appeals held in 1998 that because a special proceeding to compel or stay arbitration is no longer pending after a judgment is entered directing arbitration and the arbitration is thereafter held, all subsequent applications, such as applications to confirm or vacate an arbitration award, must be brought in a new proceeding, under a new index number.[67] The Senate and the Assembly later approved legislation that would, in effect, have overruled *Solkav* and provide that all applications relating to an arbitration be presented in the same case even if final judgment has been entered on a prior application,[68] but in 1999, Governor Pataki refused to sign it into law.

Effective August 16, 2000, however, CPLR 7502(a) was amended to effectively overrule *Solkav*, by adding a new subdivision (iii), which provides, "Notwithstanding the entry of a judgment, all subsequent applications shall be made by motion in the special proceeding or action in which the first application was made."[69] Thus, a party will no longer have to commence a new proceeding to obtain additional judicial relief with respect to the same arbitration. "The requirement that subsequent applications be made in a 'pending' proceeding has been eliminated, and the statute now expressly provides that a motion will suffice even after entry of judgment. Indeed, the commencement of a new proceeding would be improper."[70]

In *Gleason v. Michael Vee Ltd.*,[71] the Court of Appeals held that the post-*Solkav* amendment to CPLR 7502(a) should be applied retroactively to a case that was still *sub judice* at the time of the amendment.[72]

By 2001 N.Y. Laws, Chapter 567, effective December 19, 2001, the time for applying to confirm or contest an arbitration award when relief was denied solely on the grounds that it was sought in the wrong forum (such as by motion instead of special proceeding) was revised. New subdivision (a)(iv) of CPLR 7502 provides:

> If an application to confirm an arbitration award made within the one year as provided by [§ 7510] of this article, or an application to vacate or modify an award made within the ninety days as provided by subdivision a of [§ 7511] of this article, was denied or dismissed solely on the ground that it was made in the form of a motion captioned in an earlier special proceeding having reference to the arbitration instead of as a distinct special proceeding, the time in which to apply to confirm the award and the time in which to apply to vacate or modify the award may, notwithstanding that the applicable period of time has expired, be made at any time within ninety days after the effective date of this paragraph, and may be made in whatever form is appropriate (motion or special proceeding) pursuant to this subdivision.

Appeals In *Nelson v. Queens Surface Corp.*[73] and *Allstate Ins. Co. v. Romero*,[74] the courts reiterated the rule that by participating in the arbitration proceeding instead of moving to temporarily stay it, a party waives its right to seek a permanent stay of arbitration. A party must at least seek a stay of the arbitration pending the appeal, in order not to be deemed to have waived the right to appeal.[75]

UNINSURED MOTORIST ISSUES

Insurer's Duty to Provide Prompt Written Notice

Insurance Law § 3420(d) requires liability insurers to "give written notice as soon as is reasonably possible of . . . disclaimer of liability or denial of coverage to the insured and the injured person or any other claimant."

In *Columbia Casualty Co. v. National Emergency Services, Inc.*,[76] the court rejected the plaintiff's claim that Ins. Law § 3420(d) applied where the policy was issued out of state and listed the address of the insured's corporate headquarters out of state because "[t]he policy expressly covered insureds and risks located in New York and must therefore be deemed issued for delivery in New York."

In *City of New York v. Northern Ins. Co.*,[77] the court held that a two-month delay in disclaiming coverage for late notice was unreasonable as a matter of law. The court rejected the insurer's attempt to justify the delay on the ground that it had to investigate whether the plaintiff was an additional insured because that investigation was unrelated to the reason for the disclaimer and could have been asserted at any time.

In *Faas v. New York Central Mutual Fire Ins. Co.*,[78] the court held that an unexplained delay of 42 days was unreasonable as a matter of law. And, in *Brandon v. Nationwide Mutual Ins. Co.*,[79] the court held that a delay of only 34 days was unreasonable.

In *Oster v. Aetna Casualty & Surety Co.*,[80] the court held that a four-month delay in disclaiming was unreasonable. And, in *Columbia Casualty Co. v. National Emergency Services, Inc.*,[81] the court held that a 17-month delay was unreasonable as a matter of law.

On the other hand, in *Allstate Ins. Co. v. Earl*,[82] the court held that a question of fact existed as to the reasonableness of a five-week delay. And, in *Farmbrew Realty Corp. v. Tower Ins. Co.*,[83] a delay of two months was held to be reasonable because it was warranted by the insurer's need to investigate the occurrence, coupled with the inability of the insurer's investigation, through no fault of its own, to interview the insured's principal and employees and then write his report; the subsequent delay was needed to allow the insurer to receive, evaluate and act upon the report.

The New York courts have repeatedly held that for the purpose of determining whether a liability insurer has a duty to promptly disclaim in accordance with Ins. Law § 3420(d), a distinction must be made between (a) policies that contain no provisions extending coverage to the subject loss, and (b) policies that do contain provisions extending coverage to the subject loss, and which would thus cover the loss but for the existence, elsewhere in the policy, of an exclusionary clause. It is only in the former case that compliance with Ins. Law § 3420(d) may be dispensed with.[84]

"Physical contact is a condition precedent to an arbitration based upon a hit-and-run accident involving an unidentified vehicle."

In *State Farm Mutual Automobile Ins. Co. v. Joseph*,[85] the court noted that a notice of disclaimer "must promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated."

In *Eveready Ins. Co. v. DeLeon*,[86] the court held that the insurer properly and timely mailed the notice of disclaimer to the attorney of record for the insured, despite information that the insured had retained new counsel because the insurer was not in receipt of a duly executed consent to change attorney form or court order substituting counsel in accordance with CPLR 321.

In *Markevics v. Liberty Mutual Ins. Co.*,[87] the Court of Appeals reiterated the rule that timely written notice of disclaimer must be sent to the injured party as well as the insured.

Cancellation of Coverage Generally speaking, to cancel an owner's policy of liability insurance, an insurer must strictly comply with the detailed and complex statutes, rules and regulations governing notices of cancellation and termination of insurance, which differ depending upon whether, for example, the vehicle at issue is a livery or private passenger vehicle, and whether the policy was written under the Assigned Risk Plan, and/or was paid for under premium financing contract.

Nevertheless, in *Progressive Northeastern Ins. Co. v. Robbins*,[88] the court held that a notice of cancellation providing that "'*Insurance* must be *in effect* throughout the registration period'" complied with the statutory requirements of the VTL, despite the fact that it failed to use the exact language specified by the Regulations.[89]

In *Allstate Ins. Co. v. Hernandez*,[90] the court noted that, under VTL § 313(2)(a), an insurer is not required to provide notice of termination to the Commissioner of Motor Vehicles with reference to the "non-renewal of a policy which has been in force for at least six months" because such renewals are not considered "cancellations" or "terminations."

In *Rosner v. Metropolitan Property & Liability Ins. Co.*,[91] the Court of Appeals, answering a certified question from the U.S. Court of Appeals for the Second Circuit, held that for purposes of Ins. Law § 3425(a)(7), (e), which provides that "[w]ith respect to personal lines insurance policies, no notice of nonrenewal or conditional renewal of a covered policy shall be issued to become effective during the required policy period unless it is based upon a ground for which the policy could have been cancelled," the date as of which the policy is first issued, which is the date on which the three-year policy period begins to run, rather than the date on which the policy is executed, is the effective date of the policy.

Stolen Vehicles

In *Allstate Indemnity Co. v. Nelson*,[92] the court noted that VTL § 388(1) imputes to the owner of a motor vehicle the negligence of one who uses or operates it with his or her permission. This section gives rise to a presumption that the vehicle is being operated with the owner's consent, but the presumption may be rebutted by substantial evidence to the contrary.

In *Villalmil v. Budget Rental*,[93] the court held that "the failure to discover and report a theft until after the accident does not, of itself, preclude summary judgment" on the issue of permissive use.[94]

Hit-and-Run

One of the requirements for a valid uninsured motorist claim based upon a hit-and-run is "physical contact" between an unidentified vehicle and the person or motor vehicle of the claimant.

In *State Farm Mutual Automobile Ins. Co. v. Johnson*,[95] the court stated,

> Physical contact is a condition precedent to an arbitration based upon a hit-and-run accident involving an

> unidentified vehicle. While direct contact between the insured's vehicle and the unidentified vehicle is not required where the collision involves multiple vehicles, the underlying accident must originate from a "collision with an unidentified vehicle, or an integral part of an unidentified vehicle."[96]

In *Nationwide Ins. Co. v. Bellreng*,[97] the court found the requisite physical contact where the claimant was using a hose that was stretched across a road and a taxicab driven by an unidentified driver made contact with the hose, pulling the claimant into a utility pole.

In *Countrywide Ins. Co. v. Colon*,[98] the court held that proof that another vehicle "cut off" (but did not come into contact with) the claimant's vehicle, causing the claimant to lose control and strike a tree or a building did not suffice to give rise to a valid hit-and-run claim.

In *New York Central Mutual Fire Ins. Co. v. Paredes*,[99] the court held that when there is a genuine triable issue of fact with respect to whether a claimant's vehicle had any physical contact with an alleged hit-and-run vehicle, the appropriate procedure is to stay arbitration pending a hearing on that issue.

In *Irizarry v. MVAIC*,[100] the petitioner testified at a hearing that he was struck by a hit-and-run vehicle, which he identified as a white Acura. He further testified that immediately after he was struck, while he was still on the ground, an eyewitness ran up to him and told him he "took the license plate" number of the offending vehicle. The investigating police officer noted in his report that the license plate number was obtained by witnesses, who refused to give their names. The plate number given did correspond to a white Acura. In affirming an order denying a petition pursuant to Ins. Law § 5218 to permit the petitioner to commence an action against the MVAIC, and determining that the petitioner may proceed against the owner of the vehicle named in the police report, the court held that the oral statements of unidentified eyewitnesses were admissible pursuant to the present tense exception to the hearsay rule because they were made "substantially contemporaneously" with the observation, and were "sufficiently corroborated by other evidence."

In *Jenkins v. Empire/Allcity Ins. Co.*,[101] the court noted that to recover under the hit-and-run provisions of the policy, the insured must show that "neither the owner nor the operator" of the offending vehicle could be identified. And, in *New York Central Mutual Fire Ins. Co. v. Douglas*,[102] the court reiterated the rule that the claimant must use reasonable efforts to ascertain the identity of the owner and/or operator of the alleged offending vehicle.[103] In *Nationwide Mutual Ins. Co. v. McMillan*,[104] the court held that in determining whether to stay an uninsured motorist arbitration, the court could consider the insured's admissions contained in the police report and in his hospital records.

In *Don v. MGM Transport Corp.*,[105] the court noted that the insured/claimant must make out a *prima facie* case that the actions of the unidentified motorist were a proximate cause of the accident. In *Legion Ins. Co. v. Estevez*,[106] the court held that an unsworn and undated application for No-Fault benefits did not constitute a statement under oath, and the failure to provide such a statement in a hit-and-run case vitiated coverage.

Another requirement for a valid hit-and-run claim is a report to the police within 24 hours or as soon as reasonably possible.[107]

UNDERINSURED MOTORIST ISSUES

Trigger of Underinsured Coverage

In *Jones v. Peerless Ins. Co.*,[108] where the insured had a single limit policy of $100,000 for bodily injury, and the tortfeasor had $50,000/$100,000 bodily injury coverage, and the insured was the only person injured, the court held that the insured's SUM coverage was triggered after he settled with the tortfeasor for its $50,000 limits because the appropriate comparison was between the insured's single limit policy and the tortfeasor's "per person" limit.

Consent to Settle

In *Allstate Ins. Co. v. Liberati*,[109] the court ruled,

> In effecting a settlement of personal injury claims against a third-party tortfeasor arising out of a motor vehicle accident, an insured will be held to have prejudiced the subrogation rights of his insurer unless he establishes by express provision in the release executed to the third party or by necessary implication arising from the circumstances of the execution of the release that the settling parties reserved the rights of the insurer against the third-party tort-feasor or otherwise limited the extent of their settlement to achieve that result.[110]

In *American Home Assurance Co. v. Williams*,[111] the court held, "The insured was excused from his failure to obtain . . . consent to his settlement of his action against the parties who injured him because the release he executed sufficiently preserved [the insurer's] subrogation rights."

In *American Ref-Fuel Co. v. Resource Recycling, Inc.*,[112] the court stated,

> An insured's failure to comply with its obligations under an insurance policy is generally a defense to an action on the policy. However, "an insurer cannot insist upon cooperation or adherence to the terms of its policy after it has repudiated liability on the claim . . . by sending a letter denying liability." Thus, "[o]nce an insurer repudiates liability . . . the [in]sured is excused from any of its obligations under the policy."[113]

In *Allstate Ins. Co. v. Brown*,[114] respondent contended that the settlement without the consent of the SUM carrier did not prejudice the carrier's subrogation rights because those rights were extinguished by the tortfeasor's personal bankruptcy. The court rejected that contention because the respondent failed to submit proper proof establishing the bankruptcy discharge.

Effect of Release and Trust Agreement

In *Interboro Mutual Indemnity Ins. Co. v. Lindstrand*,[115] the claimants settled an uninsured motorist claim for $20,000. As part of that settlement, they executed a "release and trust agreement" by which they agreed to hold in trust for the benefit of the UM carrier all rights of recovery and to assign to it the proceeds of any settlement or judgment, and that no settlement would be made and no release would be given, and no claim would be prosecuted to judgment without its written consent. Thereafter, the claimants settled their claims with the insurer for the offending vehicle in the amount of $90,000 and executed a general release releasing the tortfeasor and his insurer from any and all liability. When the SUM carrier learned of the settlement, it sued the claimants and their attorney, a named payee on the $20,000 settlement check, to recover the $20,000 it had previously paid out. In affirming the grant of summary judgment to the SUM carrier, the court noted that under the terms of the agreement, claimants "had no right to enter into the settlement with the insurer for the third-party tortfeasor without reserving [its] subrogation rights."[116]

Reduction in Coverage

In *Spindler v. New York Central Mutual Fire Ins. Co.*,[117] and *Metropolitan Property & Casualty Ins. Co. v. Barriga*,[118] the courts noted the validity of the offset or reduction in coverage for amounts received from the tortfeasor(s) where the policy contains a single limit for "un/underinsurance."[119]

In *Le Blanc v. Allstate Ins. Co.*,[120] the plaintiff settled her case against the tortfeasor for the full available limits of his $100,000 combined single limit policy. Of the $100,000 settlement, $12,000 was reimbursed to plaintiff's insurer for the property damage payment to plaintiff for the loss of her car, and $88,000 was paid to plaintiff. Plaintiff then sought $100,000 SUM coverage under her own policy, claiming that the $88,000 paid by the tortfeasor was in partial payment of her far greater economic loss, which could be attributed to property damage, and was not payment of damages because of bodily injury, and could, therefore, not be used by the SUM insurer as an offset. The court rejected plaintiff's contention, holding that damages "arising out of" or "because of" bodily injury sustained by the insured include past and future lost wages and medical costs, which plaintiff was entitled to recover in her action against the tortfeasor. Accordingly, the court held that the SUM insurer's maximum liability was limited to $12,000.

In *Demopoulous v. New York Central Mutual Fire Ins. Co.*,[121] Passenger No. 1 died and Passenger No. 2 was seriously injured in a one-car accident. Defendant was insured for $100,000 with Insurer No. 1. Passenger No. 1's father also had SUM coverage with Insurer No. 2, with coverage of $100,000. Passengers 1 and 2 proposed that the full $100,000 of Insurer No. 1's policy be paid to Passenger No. 2, and the full $100,000 SUM coverage of Insurer No. 2 be paid to Passenger No. 1. Insurer No. 2 claimed that it should get a credit for $50,000 of Insurer No. 1's policy and only pay $50,000 out of its $100,000 coverage. The court held that Insurer No. 2 was correct and that it was entitled to the $50,000 credit because the claimants could not apportion the first $100,000 as they wanted. Insurance Law § 3420(f)(1) requires that the first $50,000 be paid on the death claim.

Priority of Coverage

The "Priority of Coverage" provision of the SUM endorsement provides that where an insured may be covered for uninsured or supplementary uninsured motorist coverage under more than one policy, the maximum amount recoverable may not exceed the highest limit of coverage for any one vehicle under any one policy. In such cases, the following order of priority applies: (1) the policy covering the vehicle occupied by the claimant; (2) the policy identifying the claimant as a named insured; and (3) any other policy covering the claimant.

In *Dudley v. Allstate Ins. Co.*,[122] the court applied the "Priority of Coverage" provision to reduce the $100,000 coverage of respondent's SUM policy by the $50,000 petitioner recovered under a higher-in-priority SUM policy.[123]

Non-Stacking

In addition to the "Priority of Coverage" provision, Regulation 35-D contains a "non-stacking" provision, which provides that regardless of the number of vehicles involved, persons covered, claims made, or premiums shown in the endorsement or premiums paid, the limits of coverage may not be added together or combined for two or more vehicles to determine the extent of insurance coverage available to an insured injured in the same accident.

In *Farmers Ins. Exchange Los Angeles, Cal. v. Knippler*,[124] the court held that the "anti-stacking" provisions of the policy are enforceable. Accordingly, the insurer's maximum liability under the SUM provisions of its five policies was limited to $100,000 (*i.e.*, the limit of coverage for one vehicle).

Statute of Limitations

Claims Against Insurers In *Allstate Ins. Co. v. Schelter*,[125] the court reiterated that claims for UM/SUM benefits against insurers are governed by the six-year statute of limitations applicable to contract actions.

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1. *See* Jonathan A. Dachs, *Actions by Courts and Legislature in 2000 Addressed Issues Affecting Uninsured and Underinsured Drivers*, N.Y. St. B.J. Vol. 74, No. 7, at 26 (Sept. 2001); Jonathan A. Dachs, *Summing Up 1999 'SUM' Decisions: Courts Provide New Guidance on Coverage Issues for Motorists*, N.Y. St. B.J. Vol. 72, No. 6, at 18 (July/Aug. 2000); Jonathan A. Dachs, *Decisions in 1998 Clarified Issues Affecting Coverage for Uninsured and Underinsured Motorists*, N.Y. St. B.J. Vol. 71, No. 5, at 8 (May/June 1999); Jonathan A. Dachs, *Legislative and Case Law Developments in UM/UIM/SUM Law—1997*, N.Y. St. B.J. Vol. 70, No. 6, at 46 (Sept./Oct. 1998); Jonathan A. Dachs, *Developments in Uninsured and Underinsured Motorist Coverage*, N.Y. St. B.J. Vol. 69, No. 6 at 18 (Sept./Oct. 1997); *The Parts of the SUM: Uninsured and Underinsured Motorist Coverage in 1995*, N.Y. St. B.J. Vol. 68, No. 5, at 42 (July/Aug. 1996); Jonathan A. Dachs, *Uninsured and Underinsured Motorist Cases in 1994*, N.Y. St. B.J. Vol 67, No. 7 at 24 (Nov. 1995); Jonathan A. Dachs, *Uninsured and Underinsured . . . But Not Underlitigated: 1993: An Important Year for UM/UIM Coverage*, N.Y. St. B.J. Vol. 66, No. 6, at 13 (Sept./Oct. 1994).
2. *Government Employees Ins. Co. v. Fabien*, N.Y.L.J., Apr. 9, 2002, p. 22, col. 3 (Sup. Ct., Nassau Co.).
3. *See Zurich Ins. Co. v. Shearson Lehman Hutton, Inc.*, 84 N.Y.2d 309, 618 N.Y.S.2d 609 (1994); *In re Allstate Ins. Co.*, 81 N.Y.2d 219, 597 N.Y.S.2d 904 (1993).
4. *Id.*; *see Eagle Ins. Co. v. Singletary*, 279 A.D.2d 56, 717 N.Y.S.2d 351 (2d Dep't 2000).
5. *See Integon Ins. Co. v. Garcia*, 281 A.D.2d 480, 721 N.Y.S.2d 660 (2d Dep't 2001); *see also Gallant v. Travelers Ins. Co.*, 280 A.D.2d 900, 721 N.Y.S.2d 187 (4th Dep't 2001) (New York law applies to issue of coverage under a New York policy on a New York registered vehicle, even though the accident occurred in Ontario, Canada).
6. 289 A.D.2d 330, 733 N.Y.S.2d 734 (2d Dep't 2001).
7. 96 N.Y.2d 58, 724 N.Y.S.2d 692 (2001).
8. *See AIU Ins. Co. v. Elrac, Inc.*, 287 A.D.2d 668, 732 N.Y.S.2d 105 (2d Dep't 2001).
9. 282 A.D.2d 680, 724 N.Y.S.2d 431 (2d Dep't 2001).
10. 286 A.D.2d 699, 730 N.Y.S.2d 152 (2d Dep't 2001).
11. 281 A.D.2d 411, 721 N.Y.S.2d 400 (2d Dep't 2001).
12. *Id.*; *see State Farm Mut. Auto. Ins. Co. v. Bennett*, 289 A.D.2d 496, 734 N.Y.S.2d 637 (2d Dep't 2001); *State Farm Mut. Auto. Ins. Co. v. McKoy*, 288 A.D.2d 375, 732 N.Y.S.2d 870 (2d Dep't 2001); *Travelers Prop. Cas. Co. v. Lee*, 283 A.D.2d 583, 724 N.Y.S.2d 903 (2d Dep't 2001); *Continental Ins. Co. v. Josephson*, 280 A.D.2d 546, 720 N.Y.S.2d 392 (2d Dep't 2001).
13. 93 N.Y.2d 487, 693 N.Y.S.2d 81 (1999).
14. 284 A.D.2d 1002, 726 N.Y.S.2d 522 (4th Dep't 2001).
15. 284 A.D.2d 332, 725 N.Y.S.2d 564 (2d Dep't 2001).
16. 280 A.D.2d 923, 721 N.Y.S.2d 178 (4th Dep't 2001).
17. 288 A.D.2d 925, 732 N.Y.S.2d 822 (4th Dep't 2001).
18. 280 A.D.2d 476, 720 N.Y.S.2d 172 (2d Dep't 2001).
19. 284 A.D.2d 1002, 726 N.Y.S.2d 522 (4th Dep't 2001).
20. N.Y.L.J., Apr. 16, 2001, p. 39, col. 6 (Sup. Ct., Sullivan Co.).
21. *Id.*; *see State Farm Mutual Auto. Ins. Co. v. Fuccio*, 288 A.D.2d 46, 732 N.Y.S.2d 220 (1st Dep't 2001).
22. N.Y.L.J., July 31, 2000, p. 35, col. 3 (Sup. Ct., Richmond Co.), *aff'd*, 286 A.D.2d 708, 730 N.Y.S.2d 156 (2d Dep't 2001).
23. *See* N.Y. Insurance Law § 3420(a)(2), (b) ("Ins. Law").
24. 284 A.D.2d 924, 727 N.Y.S.2d 222 (4th Dep't 2001).
25. N.Y.L.J., Apr. 16, 2001, p. 39, col. 6 (Sup. Ct., Sullivan Co.).
26. *Id.*; *see American Cas. Ins. Co. v. Silverman*, 271 A.D.2d 528, 705 N.Y.S.2d 676 (2d Dep't 2000); *see also* Feeney & Fitzpatrick, *When is Notice Actually Notice in Uninsured Claims?*, N.Y.L.J., July 31, 2001, p. 1, col. 1.
27. *See Lancer Ins. Co./Teachers' Ins. Plan v. Sciandra*, 282 A.D.2d 535, 722 N.Y.S.2d 764 (2d Dep't 2001).
28. 288 A.D.2d 806, 733 N.Y.S.2d 761 (3d Dep't 2001).
29. *See Brandon v. Nationwide Mut. Ins. Co.*, 284 A.D.2d 886, 727 N.Y.S.2d 727 (3d Dep't 2001); *Valley Forge Ins. Co. v. Schofield*, 283 A.D.2d 507, 724 N.Y.S.2d 870 (2d Dep't 2001); *see also CGU Ins. Co. v. Nardelli*, 188 Misc. 2d 560, 729 N.Y.S.2d 365 (Sup. Ct., Westchester Co. 2001).
30. 97 N.Y.2d 491, ____ N.Y.S.2d ____ (2002).
31. 280 A.D.2d 472, 719 N.Y.S.2d 217 (2d Dep't 2001).
32. 289 A.D.2d 333, 734 N.Y.S.2d 570 (2d Dep't 2001).
33. 288 A.D.2d 309, 732 N.Y.S.2d 890 (2d Dep't 2001).
34. 287 A.D.2d 640, 732 N.Y.S.2d 21 (2d Dep't 2001).
35. CPLR 7502 now provides that

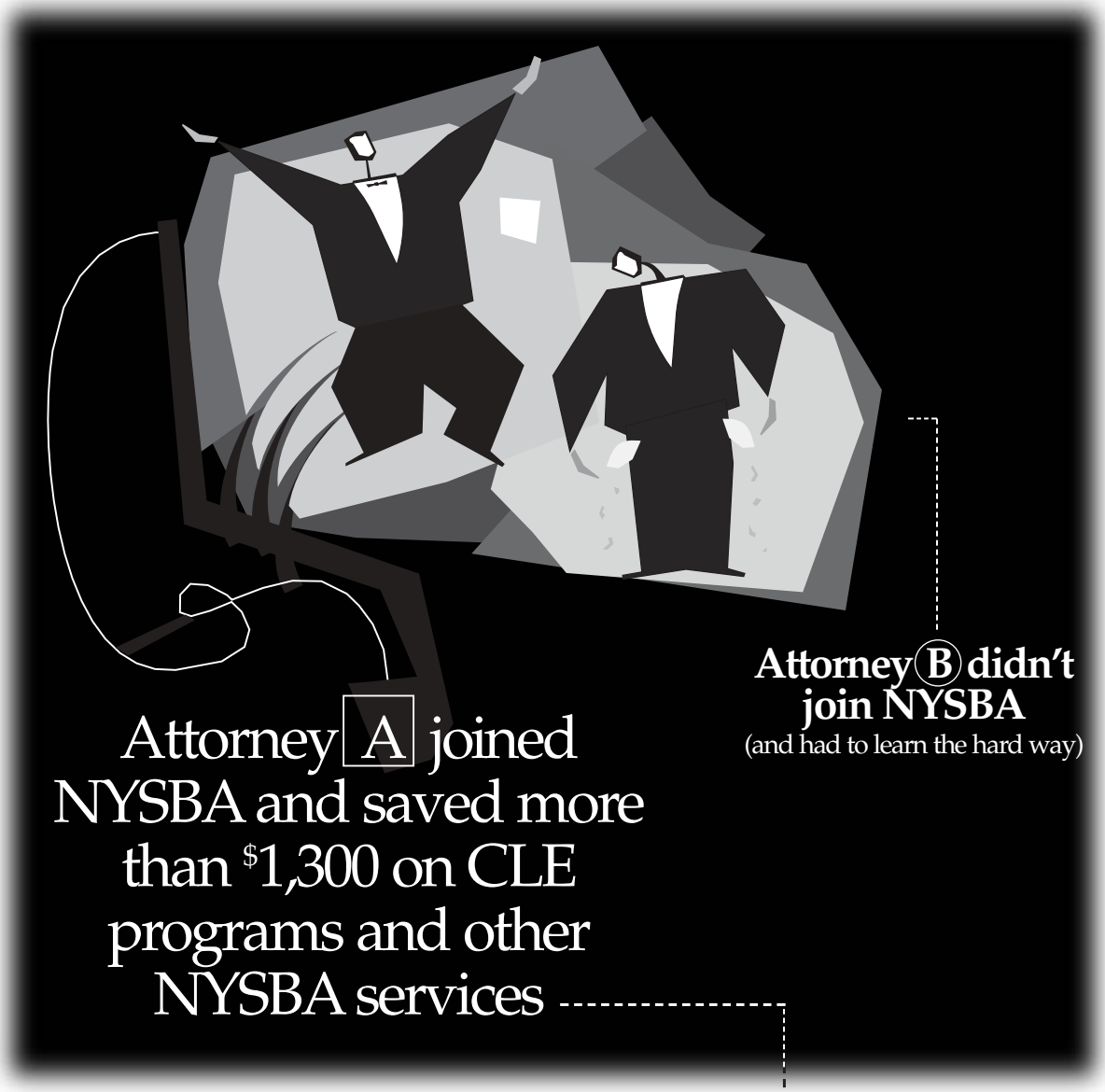
    > (i) The proceeding shall be brought in the court and county specified in the agreement. If the name of the county is not specified, proceedings to stay or bar arbitration shall be brought in the county where the party seeking arbitration resides or is doing business, and other proceedings affecting arbitration are to be brought in the county where at least one of the parties resides or is doing business or where the arbitration was held or is pending.
    >
    > (ii) If there is no county in which the proceeding may be brought under paragraph (i) of this subdivision, the proceeding may be brought in any county.

36. N.Y.L.J., Apr. 16, 2001, p. 38, col. 4 (Sup. Ct., Nassau Co.).
37. 286 A.D.2d 769, 730 N.Y.S.2d 522 (2d Dep't 2001).
38. *See GEICO v. Raganath*, 288 A.D.2d 472, 733 N.Y.S.2d 894 (2d Dep't 2001); *Phoenix Ins. Co. v. Casteneda*, 287 A.D.2d 507, 731 N.Y.S.2d 224 (2d Dep't 2001).
39. N.Y.L.J., Jan. 22, 2002, p. 25, col. 3 (Sup. Ct., Nassau Co.).
40. *Id.*; *see* Vincent C. Alexander, *Venue in Judicial Proceedings Relating to Arbitration*, N.Y.L.J., Mar. 18, 2002, p. 3, col. 1.
41. *See Matarasso v. Continental Cas. Co.*, 56 N.Y.2d 264, 451 N.Y.S.2d 703 (1982); *Amica Ins. Co. v. Mupo*, N.Y.L.J., Sept. 21, 2001, p. 21, col. 6 (Sup. Ct., Suffolk Co. 2001); *see also State Farm Mut. Auto Ins. Co. v. Mandala*, 284 A.D.2d 472, 726 N.Y.S.2d 860 (2d Dep't 2001).
42. 288 A.D.2d 42, 732 N.Y.S.2d 564 (1st Dep't 2001).
43. 281 A.D.2d 377, 722 N.Y.S.2d 543 (1st Dep't 2001).
44. 189 Misc. 2d 605, 735 N.Y.S.2d 363 (Sup. Ct., Nassau Co. 2001).
45. *See Fry v. Village of Tarrytown*, 226 A.D.2d 461, 641 N.Y.S.2d 54 (2d Dep't 1996), *rev'd on other grounds*, 89 N.Y.2d 714, 658 N.Y.S.2d 205 (1997); N. Dachs & J. Dachs, *Petitions to Stay Arbitration: Special Proceedings*, N.Y.L.J., July 8, 1997, p. 3, col. 1.
46. 95 N.Y.2d 605, 721 N.Y.S.2d 597 (2001).
47. *See* 2001 N.Y. Laws ch. 473, § 2, *amending* CPLR 304, 306-a, 306-b.

48. *See* Vincent C. Alexander, *Special Proceedings: New Commencement Amendment Is Incomplete*, N.Y.L.J., Feb. 14, 2002, p. 3, col. 1:

    > Until this oversight is corrected (or the appellate courts provide some creative remedy), practitioners who, because of exigent circumstances, must commence a special proceeding on the eve of expiration of the statute of limitations are urged to proceed with extreme caution. Insofar as the statute of limitations is concerned, they can take no comfort whatsoever in the amended version of CPLR 304.

49. *See GEICO v. Williams-Staley*, 288 A.D.2d 471, 733 N.Y.S.2d 74 (2d Dep't 2001); *Maryland Cas. Ins. Co. v. Lopez*, 287 A.D.2d 719, 732 N.Y.S.2d 57 (2d Dep't 2001).
50. *See Lopez*, 287 A.D.2d 719.
51. *See Liberty Mut. Ins. Co. v. Hutardo*, 289 A.D.2d 334, 733 N.Y.S.2d 733 (2d Dep't 2001).
52. 286 A.D.2d 500, 729 N.Y.S.2d 739 (2d Dep't 2001).
53. 288 A.D.2d 471, 733 N.Y.S.2d 74 (2d Dep't 2001).
54. 288 A.D.2d 474, 732 N.Y.S.2d 905 (2d Dep't 2001).
55. 281 A.D.2d 365, 722 N.Y.S.2d 166 (1st Dep't 2001).
56. 281 A.D.2d 330, 723 N.Y.S.2d 9 (1st Dep't 2001).
57. 282 A.D.2d 541, 722 N.Y.S.2d 770 (2d Dep't 2001).
58. 283 A.D.2d 982, 723 N.Y.S.2d 924 (4th Dep't 2001).
59. 286 A.D.2d 587, 730 N.Y.S.2d 90 (1st Dep't 2001).
60. 289 A.D.2d 105, 734 N.Y.S.2d 164 (1st Dep't 2001).
61. 289 A.D.2d 331, 735 N.Y.S.2d 138 (2d Dep't 2001).
62. 189 Misc. 2d 467, 733 N.Y.S.2d 847 (Civil Ct., Queens Co. 2001).
63. 97 N.Y.2d 659, 738 N.Y.S.2d 1 (2001).
64. No. 2000-1467 QC, 2001 N.Y. Misc. LEXIS 854 2001 WL 1703079 (App. Term, 2d and 11th Dists. Nov. 7, 2001).
65. *Id*. (citations omitted).
66. 286 A.D.2d 437, 729 N.Y.S.2d 391 (2d Dep't 2001).
67. *Solkav Solartechnik, G.m.b.H. v. Besicorp Group Inc.*, 91 N.Y.2d 482, 672 N.Y.S.2d 838 (1998).
68. Senate Bill No. 3071-A and Assembly Bill No. 5937-A.
69. *See* 2000 N.Y. Laws ch. 226, § 1.
70. *See* Vincent C. Alexander, *Special Proceedings Relating to Arbitration: New Developments*, N.Y.L.J., Sept. 20, 2000, p. 3, col. 1.
71. 96 N.Y.2d 117, 726 N.Y.S.2d 45 (2001).
72. *See* David D. Siegel, New York State Law Digest, No. 497 (May 2001).
73. 283 A.D.2d 577, 724 N.Y.S.2d 895 (2d Dep't 2001).
74. 279 A.D.2d 522, 718 N.Y.S.2d 871 (2d Dep't 2001).
75. *See Commerce & Indus. Ins. Co. v. Nester*, 90 N.Y.2d 255, 660 N.Y.S.2d 366 (1997).
76. 282 A.D.2d 346, 723 N.Y.S.2d 473 (1st Dep't 2001).
77. 284 A.D.2d 291, 725 N.Y.S.2d 374 (2d Dep't 2001).
78. 281 A.D.2d 586, 722 N.Y.S.2d 173 (2d Dep't 2001).
79. 284 A.D.2d 886, 727 N.Y.S.2d 727 (3d Dep't 2001), *aff'd on other grounds*, 97 N.Y.2d 491, ___ N.Y.S.2d ___ (2002).
80. 283 A.D.2d 409, 724 N.Y.S.2d 198 (2d Dep't 2001).
81. 282 A.D.2d 346, 723 N.Y.S.2d 473 (1st Dep't 2001).
82. 284 A.D.2d 1002, 726 N.Y.S.2d 522 (4th Dep't 2001).
83. 289 A.D.2d 284, 734 N.Y.S.2d 592 (2d Dep't 2001).
84. *See Worcester Ins. Co. v. Bettenhauser*, 95 N.Y.2d 185, 712 N.Y.S.2d 433 (2000); *Allstate Indem. Co. v. Nelson*, 285 A.D.2d 545, 728 N.Y.S.2d 82 (2d Dep't 2001); *Interested Underwriters at Lloyds v. Midge Rest. Corp.*, 283 A.D.2d 459, 724 N.Y.S.2d 632 (2d Dep't), *appeal denied*, 96 N.Y.2d 721, 733 N.Y.S.2d 373 (2001); *Commissioners of the State Ins. Fund v. Aetna Cas. & Sur. Co.*, 283 A.D.2d 335, 728 N.Y.S.2d 6 (1st Dep't 2001).
85. 287 A.D.2d 724, 732 N.Y.S.2d 66 (2d Dep't 2001).
86. 287 A.D.2d 536, 731 N.Y.S.2d 642 (2d Dep't 2001).
87. 97 N.Y.2d 646, 735 N.Y.S.2d 865 (2001).
88. 279 A.D.2d 631, 720 N.Y.S.2d 153 (2d Dep't 2001).
89. *Id*. at 631 (emphasis added) (relying on *Barile v. Kavanaugh*, 67 N.Y.2d 392, 398 n.3, 502 N.Y.S.2d 977 (1986)). *See Allstate Ins. Co. v. Caulfield*, 288 A.D.2d 212, 732 N.Y.S.2d 374 (2d Dep't 2001).
90. 282 A.D.2d 451, 723 N.Y.S.2d 65 (2d Dep't 2001).
91. 96 N.Y.2d 475, 729 N.Y.S.2d 658 (2001).
92. 285 A.D.2d 545, 728 N.Y.S.2d 82 (2d Dep't 2001).
93. 281 A.D.2d 207, 721 N.Y.S.2d 638 (1st Dep't 2001).
94. *See Pow v. Black*, 182 A.D.2d 484, 582 N.Y.S.2d 186 (1st Dep't 1992).
95. 287 A.D.2d 640, 732 N.Y.S.2d 21 (2d Dep't 2001).
96. *Id.* at 640–41 (citations omitted); *see Interboro Mut. Ins. Co. v. Devone*, 189 Misc. 2d 605, 735 N.Y.S.2d 366 (Sup. Ct., N.Y. Co. 2001).
97. 288 A.D.2d 925, 732 N.Y.S.2d 822 (4th Dep't 2001).
98. 279 A.D.2d 427, 720 N.Y.S.2d 71 (1st Dep't 2001).
99. 289 A.D.2d 495, 735 N.Y.S.2d 179 (2d Dep't 2001).
100. 287 A.D.2d 716, 732 N.Y.S.2d 54 (2d Dep't 2001).
101. 289 A.D.2d 331, 735 N.Y.S.2d 138 (2d Dep't 2001).
102. 287 A.D.2d 720, 732 N.Y.S.2d 58 (2d Dep't 2001).
103. *See Sweet v. MVAIC*, 287 A.D.2d 510, 731 N.Y.S.2d 391 (2d Dep't 2001) (the identities of an eyewitness and a passenger in the alleged offending vehicle were noted in the police report—claimant failed to demonstrate that he took "all reasonable efforts" to obtain the testimony of these witnesses to assist in identifying the offending vehicle).
104. 288 A.D.2d 224, 732 N.Y.S.2d 431 (2d Dep't 2001).
105. 279 A.D.2d 446, 718 N.Y.S.2d 867 (2d Dep't 2001).
106. 281 A.D.2d 420, 721 N.Y.S.2d 273 (2d Dep't 2001).
107. *See GEICO v. Snell*, 286 A.D.2d 682, 729 N.Y.S.2d 779 (2d Dep't 2001).
108. 281 A.D.2d 888, 721 N.Y.S.2d 890 (4th Dep't 2001).
109. 280 A.D.2d 922, 720 N.Y.S.2d 681 (4th Dep't 2001).
110. *Id.* at 922–23 (citation omitted).
111. 282 A.D.2d 674, 723 N.Y.S.2d 409 (2d Dep't 2001).
112. 281 A.D.2d 573, 722 N.Y.S.2d 570 (2d Dep't 2001).
113. *Id*. at 574 (citations omitted).
114. 288 A.D.2d 955, 732 N.Y.S.2d 612 (4th Dep't 2001).
115. 289 A.D.2d 450, 734 N.Y.S.2d 634 (2d Dep't 2001).
116. *See Nationwide Mut. Ins. Co. v. Sinclair*, 217 A.D.2d 686, 629 N.Y.S.2d 812 (2d Dep't 1995).
117. 283 A.D.2d 762, 727 N.Y.S.2d 483 (3d Dep't 2001).
118. 281 A.D.2d 200, 727 N.Y.S.2d 304 (1st Dep't 2001).
119. *See Goldman v. GEICO Gen. Ins. Co.*, N.Y.L.J., Jan. 26, 2001, p. 28, col. 3 (Sup. Ct., N.Y. Co.); *aff'd*, ___ A.D.2d ___, 739 N.Y.S.2d 360 (1st Dep't 2002).
120. 279 A.D.2d 876, 719 N.Y.S.2d 731 (3d Dep't 2001).
121. 280 A.D.2d 855, 720 N.Y.S.2d 289 (3d Dep't 2001).
122. 281 A.D.2d 941, 722 N.Y.S.2d 448 (4th Dep't 2001).
123. *See Allstate Ins. Co. v. DeVitt*, 288 A.D.2d 469, 733 N.Y.S.2d 248 (2d Dep't 2001); *Allstate Ins. Co. v. Earl*, 284 A.D.2d 1002, 726 N.Y.S.2d 522 (4th Dep't 2001); *Brasco v. Nationwide Mut. Ins. Co.*, 283 A.D.2d 492, 724 N.Y.S.2d 488 (2d Dep't 2001).
124. 285 A.D.2d 464, 727 N.Y.S.2d 338 (2d Dep't 2001).
125. 280 A.D.2d 910, 720 N.Y.S.2d 685 (4th Dep't 2001).



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Aggrieved Disability Policyholders In New York Are Not Limited To Past Benefits as Remedy

By Michael S. Hiller

As litigation between disabled persons and their insurance carriers becomes more widespread, it is important to understand the remedies available to policyholders before commencing an action.

One of the prevailing myths is that, in New York, recovery of past disability benefits is the sole remedy that may be granted to insured individuals aggrieved by an insurance carrier's breach of an individual[1] disability policy.[2] This myth is often based upon a misreading of several frequently cited, although largely misunderstood, state and federal court decisions. Although seemingly contradictory, the cases present a clear line of authority confirming an insured's right to seek damages, not only for past disability benefits, but also for repudiation and bad faith, even in the absence of insurer misconduct directed at the general public. And, this clear line was strengthened last year by decisions of the state Supreme Court in *Wurm v. Commercial Ins. Co. of Newark, N.J.*[3] and the Appellate Division in *Acquista v. New York Life Ins. Co.*[4] Indeed, as described below, the availability of these remedies is not only supported by existing precedent, it is also sustained by considerations of public policy.[5]

Availability of Damages for Repudiation

In the context of disability insurance, the courts have consistently held that, under the theory of repudiation, "special circumstances" may warrant imposition of damages for immediate lump-sum payment of future benefits otherwise due under a disability policy.[6] One such "special circumstance" identified by the courts exists when the insurance carrier "calls off the whole arrangement."[7] In *Bell v. Mutual Benefit Health & Accident Ass'n of Omaha*, the court held that an insured may recover the present-day value of future benefits in lump sum in cases in which an insurer informs an insured that the former will not further perform under the policy (*i.e.*, not pay any further claims or benefits), declines future premiums, or otherwise cancels its insurance contract.[8] The court in *Bell* concluded that, under such circumstances, an insured "with legitimate claims should not be forced to resort to repeated lawsuits" to recover the benefits due.[9] The *Bell* decision has been cited with approval by the First and Second Departments on this particular issue and remains good law.[10]

Most recently, in *Wurm*, the court declined to set aside a jury verdict granting the plaintiff-insured the present-day value of future benefits for the defendants' repudiation of a disability policy.[11] The plaintiff had established that she had been informed by her carrier that she would never again receive any benefits under her policy, thereby terminating the relationship and abrogating the insurance contract.[12] This testimony was confirmed at trial by (1) one of the defendant-carrier's former employees and (2) the insurer's refusal to send the plaintiff any further premium statements after terminating her benefits.[13] Following the *Bell* decision, the court in *Wurm* concluded that "where the insurance company 'calls off' the whole arrangement, the plaintiff-insured should not be required to resort to repeated lawsuits" to recover benefits owed for repudiation of the policy.[14]

The decision in *Wurm* was cited with approval by the U.S. District Court for the Southern District of New York in *Scherer v. Equitable Life Assurance Society of U.S.*[15] The multiplicity of decisions affirming the right of an insured to recover damages for repudiation, coupled with the recent jury verdict in *Wurm*, confirm the continuing vitality of claims for the present-day value of future benefits in disability cases.[16]

Availability of Attorneys' Fees When a Carrier Acts in Bad Faith

The concept of bad faith has several different meanings in insurance litigation. The most frequent use of the

Michael S. Hiller is a founding member of Weiss & Hiller, PC in Manhattan, concentrating in Commercial Litigation and Insurance Law. He is a graduate of Union College and received his J.D. from The American University, Washington College of Law.

term refers to circumstances in which an insured, after being sued by a third party for a covered liability, is subjected to a damage award in excess of policy limits as a result of the carrier's wrongful refusal to settle.[17] In such circumstances, the insured is entitled not only to compensatory damages to reimburse the cost of satisfying the ultimate judgment, but also to punitive damages in many instances.[18]

In the context of disability insurance litigation, there is no third party; instead, the focus is on the carrier's conduct in investigating, assessing and ultimately determining the insured's entitlement to benefits. And, in such first-party cases, the remedy for bad faith is not punitive damages (which are rarely recoverable in New York), but rather reimbursement of the insured's legal fees and expenses in prosecuting the claim against the insurance carrier.

"There is no reason to limit damages recoverable for breach of a duty to investigate, bargain, and settle claims in good faith to the amount specified in the insurance policy."

The New York State Court of Appeals initially established an insured's right to recover legal fees for bad faith in first-party cases, in *Sukup v. State*.[19] The Court explained that, where a carrier "evinces gross disregard for its policy obligation," an insured may recover legal fees and expenses.[20] Over the years, the courts have interpreted *Sukup* to permit recovery of attorneys' fees for bad faith in situations where an insurance carrier commences an investigation to find a "bogus basis" for denying benefits or otherwise engages in a "disingenuous or dishonest failure to carry out" the policy.[21]

For example, in *New England Mutual Ins. Co. v. Johnson*,[22] the insured, a homosexual, purchased a life insurance policy and listed as his beneficiary his business partner, a man with whom he also had a romantic relationship. When the insured died of AIDS, the carrier, upon learning the cause of death, "searched through its files in an effort to determine a way to escape its obligation" and avoid paying benefits to the beneficiary of the policy.[23] The court held that, under the circumstances, an award of attorneys' fees was necessary to deter the insurance carrier and others similarly situated from engaging in such misconduct.[24]

In *Wurm*, the court also granted the plaintiff-insured attorneys' fees for bad faith;[25] the jury determined, and the court, in refusing to set the verdict aside, subsequently affirmed, that the carrier had *actually determined* the plaintiff to be permanently and totally disabled, and yet, despite this knowledge and understanding, engaged in a relentless and purposeful investigation designed to create the knowingly false impression that she had recovered sufficiently from her injuries to return to her occupation as a dentist.[26] The court concluded that, under the circumstances, an award of attorneys' fees for bad faith was factually supported by the jury's verdict and consistent with precedent. The *Wurm* decision reinforces the continuing vitality of the attorneys' fees remedy in first-party cases for an insurer's bad faith.

Expansion of Remedies for Bad Faith

For more than 30 years, an insured's sole remedy available in New York for a carrier's bad faith in the context of first-party coverage (in the absence of evidence of a public-wide injury) was attorneys' fees. However, in *Acquista*, the Appellate Division, First Department, expanded the remedies for an insurer's bad faith to include recovery of consequential damages.[27] In *Acquista*, a disability case, the court reversed dismissal of the plaintiff-insured's allegations of bad faith, stating that "there is no reason to limit damages recoverable for breach of a duty to investigate, bargain, and settle claims in good faith to the amount specified in the insurance policy."[28]

The court in *Acquista* stated that its expansion of remedies was made necessary by reason of certain financial and other real-world considerations that regularly influence carriers' decisions regarding coverage. For example, the court explained that "if statutory interest is lower than that which the insurer can earn on the sums payable [*i.e.*, benefits due to the insured], the insurer has a financial incentive to decline to cover or pay on a claim."[29] Thereafter, in surprisingly sweeping language, the court described wrongful denials and terminations of first-party disability insurance coverage as a national problem, explaining in part: "The problem of dilatory tactics by insurance companies seeking to delay and avoid payment of proper claims has apparently become widespread enough to prompt most states to respond with some sort of remedy for aggrieved policyholders."[30] The court concluded that, "[i]n view of the inadequacy of contract remedies where an insurer purposefully declines or avoids a claim without a reasonable basis for doing so," an insured should have the right to obtain consequential damages for bad faith.[31]

Notably absent from the *Acquista* decision was any language relating to an award of attorneys' fees for bad faith. However, a review of the briefs submitted on appeal in *Acquista* confirms that the plaintiff-insured in that case never sought, and thus did not appear to argue

entitlement to, attorneys' fees for bad faith.[32] The plaintiff-insured in *Acquista* did not cite the decisions in *Sukup*, *New England Mutual*, and *FDIC v. National Surety Corp.* in support of the claim for bad faith.[33] Accordingly, the First Department did not address the issue.[34]

The advent of the decisions in *Acquista* and *Wurm* reflect a growing recognition that mere payment of past benefits plus reinstatement are insufficiently remedial to compensate policyholders for insurer misconduct. With the addition of a consequential damages remedy, insured individuals will receive enhanced protections against bad-faith practices taken by carriers.

Public Policy Considerations In Bad Faith Cases

As noted in *Standards for Limiting the Tort of Bad Faith Breach of Contract*:

> The adhesionary aspects of the insurance contract, including the lack of bargaining strength of the insured, the contracts' standardized terms, the motivation of the insured for entering into the transaction and the nature of the service for which the contract is executed, distinguish this contract [an insurance contract] from most other non-insurance commercial contracts. These features characteristic of the insurance contract make it particularly susceptible to public policy considerations.[35]

As a matter of public policy, the First Department in *Acquista* recognized that the dynamic relationship between policyholders and their carriers required the expansion of remedies available in cases of bad faith. As explained in *Acquista*, one aspect of this dynamic is that, in the absence of an adequate remedy for bad faith, insurers are not threatened with any adverse consequences for a baseless denial or termination of benefits. As discussed above, the insurer would be permitted to retain the disability benefits otherwise payable to the insured during the pendency of the action by the insured to enforce the policy. If the carrier can earn a greater return on the withheld benefit moneys than the rate of statutory interest (and, at 9%, this threshold is not difficult to transcend), it makes a profit on its denial even if it ultimately loses the case. In enhancing the remedies available for an insurer's bad faith, the court in *Acquista* identified this skewed dynamic. However, the financial incentive to insurers to deny or terminate benefits transcends what was addressed in *Acquista*.

Most individual disability policies suspend an insured's obligation to pay premiums during the period of disability. In the event of a permanent disability, an insurance carrier will never receive future premiums under the policy. Thus, the carrier has effectively received all of the consideration that it would be entitled to receive under the insurance contract, but will nonetheless have a continuing legal obligation to make benefit payments for the remainder of the insured's life (or until age 65, depending on the policy). At that point, the insurer has absolutely no financial incentive, *vis à vis* its relationship with its policyholder, to pay the insured's claim unless threatened with larger liability, *i.e.*, attorneys' fees and other damages.

Moreover, it is not as if the insured can threaten to violate the insurance contract as a means of retaliating against the carrier for wrongful denial or termination of benefits. Because the insured's obligation to make premium payments is extinguished at the time of disability, a threat of retaliatory breach by the policyholder would be an empty one. The carrier has nothing at stake other than its own obligation to pay benefits. Without adequate remedies for bad faith, insurers would have nothing to lose financially by knowingly denying or terminating benefits in situations in which they are aware of the policyholder's disability.

Aside from the skewed financial incentives to deny benefits, there are additional considerations when evaluating the public-policy implications of allowing enhanced remedies for "bad faith" claims against an insurer which were not addressed by the court in *Acquista*. For example, most insureds who are disabled cannot afford to hire and pay attorneys on an hourly basis to prosecute disability claims. Unable to work, the policyholders generally lack an income and are thus resigned to seek lawyers on a contingency-fee basis. If the sole remedy available to insureds were mere past benefits, most lawyers would be reluctant to accept disability cases on contingency, unless the policyholder waited a sufficiently long period of time (two years or more depending on the monthly benefit in the policy) to accumulate enough past benefits to make the case worthwhile financially (to the attorney). After all, one-third of a year's benefits at $5,000 per month is still just $20,000. Few competent practitioners would assume the obligation to litigate a disability case from inception to verdict on a contingency-fee basis under such circumstances; it simply would not make economic sense. This would impress upon the insured the Hobbesian choice of either (1) attempting to return to work, despite a disability; (2) not working and waiting years before commencing an action (to make the case economically advantageous for lawyers working on a contingency fee), only to receive a smaller percentage of benefits later (after the fee and costs of litigation are deducted); or (3) endeavoring to pay a lawyer on an hourly basis and risking insolvency in the process.

This choice would be made even more difficult by the economic realities confronting any potential claimant. The insured bringing the disability claim has purchased the policy to protect against the inability to work in a chosen occupation, usually a profession or executive po-

sition. These individuals typically have higher salaries, with correspondingly increased financial obligations (*i.e.*, mortgages, school tuition for children, cars and other items of significant expense). Confronted with the inability to work and catastrophic loss of income, many policyholders with looming financial difficulty would simply capitulate and either withdraw or compromise their claims (for pennies on the dollar) after considering the prospect of a lawsuit against a well-financed insurance company with a battery of lawyers. Indeed, the Kentucky Supreme Court, in establishing an insured's right to obtain punitive damages for bad faith, has observed that insurers, in obvious recognition of these circumstances, often "attempt unfair compromise [*i.e.*, offering far less than the actual value of the benefits in lump sum] by exploiting the policyholder's economic circumstance[s]."[36] Certainly, the prospect of paying an attorney on an hourly basis is sufficiently daunting for any individual, not to mention one without an income. The availability of enhanced remedies for insurer misconduct was essential to reducing the economic disparities in the dynamic between policyholder and carrier.

Although currently available only in circumstances demonstrative of repudiation, damages for future benefits may well be in the offing even in the absence of such proof.

Public Policy Considerations Affecting Remedies for Repudiation

Although currently available only in circumstances demonstrative of repudiation, damages for future benefits may well be in the offing even in the absence of such proof. As pointed out in *Robbins v. Travelers' Ins. Co.*, a disability insurance policy is a single contract; "the fact that [the] defendant [insurer] is required to perform in part at stated intervals does not change its unitary character into a multiplicity of contracts, each relating to but one installment."[37] The court in *Robbins* explained that once the disability benefits are terminated, there is nothing left to the insurance contract from the insured's perspective; such circumstances dictate that the dispute ought to be resolved as a single claim, in a single lawsuit.[38]

The rationale underlying the decision in *Robbins* is consistent with that relied upon in other contexts involving contracts to pay money in installments. For example, in cases to enforce the terms of promissory notes, lenders are entitled to declare a default when any one payment remains unpaid and then immediately demand the entire sum due. The lender need not rely on the theory of repudiation; once the borrower defaults in making payments, the lender can accelerate the loan and collect the entire balance. Cases arising from breach of disability contracts should be treated no differently. One can only imagine the uproar from financial institutions if banks and other institutional lenders, in cases arising from breached installment contracts, were limited in their recovery to only those sums due as of the date of the lawsuit, with all future payments deferred pending the remainder of the payout.

Moreover, where an insurer purposely denies or terminates benefits, despite the fact that its employees believe (or, in good conscience, should believe) that the insured was disabled, the carrier should not be permitted to cling to the policy's installment provisions under the false notion that a contract of sorts still exists. Public policy dictates that, where an insurer denies a claim that its employees know (or have good reason to know) is valid, or otherwise engages in bad faith, there is a repudiation of the policy, even in the absence of the "special circumstances" identified in *Bell*, entitling the insured to future benefits rather than subjecting the policyholder to further acts of misconduct by the carrier.[39] As the law develops in this area, an expansion of remedies for breach of a disability policy by the insurance carrier, particularly in circumstances suggesting bad faith, will likely continue.[40]

Conclusion

As implied by the First Department in *Acquista*, denial of first-party benefits, particularly in disability insurance cases, has become common on a nationwide basis. If the sole remedy recoverable against a disability insurance carrier were what would be payable to the policyholder in the first instance, the financial incentives to deny benefits, however unreasonable such denial may be, would be too economically enticing for insurers to ignore. The decisions in *Wurm* and *Acquista* represent important steps in the ongoing evolution of the law in this area. Given considerations of public policy, the evolution is likely to continue in the future.

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1. This article does not address an insured's rights pursuant to group policies under ERISA, which raises an entirely different set of issues.
2. Indeed, two partners from a highly regarded insurance-defense firm recently argued in an Outside Counsel submission to the *New York Law Journal* that the Court of Appeals had all but eliminated bad faith as a substantive allegation and claim in first-party insurance litigation. E. Krinik & N. Tolle, *Appellate Ruling Roils Bad Faith Waters*, N.Y.L.J., Oct. 18, 2001, p. 1, col. 1. The Court of Appeals's decisions to which Messrs. Krinik and Tolle referred, and

the propositions upon which these writers relied, pertained only to *punitive damages* awards arising from bad faith claims, not attorneys' fees which, as discussed in this article, continue to be recoverable under New York law.

3. N.Y.L.J., Oct. 15, 2001, p. 21, col. 1 (Sup. Ct., N.Y. Co.).
4. 285 A.D.2d 73, 730 N.Y.S.2d 272 (1st Dep't 2001). The *Acquista* decision was not appealed.
5. This article does not address any of the practical aspects relating to an effort to obtain past disability benefits or other contractual remedies which, of course, involve a different set of issues and considerations.
6. *Romar v. Alli*, 120 A.D.2d 420, 501 N.Y.S.2d 877, 878 (1st Dep't 1986); *Apostolou v. Mutual of Omaha Ins. Co.*, 72 A.D.2d 781, 421 N.Y.S.2d 600, 601 (2d Dep't 1979); *Robbins v. Travelers' Ins. Co.*, 151 Misc. 151, 269 N.Y.S. 841, 842–43 (Sup. Ct., N.Y. Co.), *aff'd*, 241 A.D. 350, 272 N.Y.S. 551 (1st Dep't 1934) (breach of the obligation to make installment payments under a disability insurance policy entitles the insured to collect the entire unpaid balance in lump sum). Though the courts in *Romar* and *Apostolou*, based upon the particular facts of those cases, denied future damages to the plaintiff-insureds therein, both courts took pains to emphasize the availability of a future-damage remedy under circumstances evincing repudiation.
7. *Bell v. Mutual Benefit Health & Accident Ass'n*, 19 Misc. 2d 754, 192 N.Y.S.2d 854, 855 (Sup. Ct., Bronx Co. 1959); *see Robbins*, 151 Misc. at 152; *Brauner v. Provident Life & Cas. Ins. Co.*, 97-CV-3556, 1998 U.S. Dist. LEXIS 23042 (E.D.N.Y. Mar. 24, 1998) ("The rule against anticipatory breach is not absolute. A plaintiff can recover a judgment regarding future benefits if, for example, the plaintiff is able to show that the insurer completely repudiated the contract.").
8. *Bell*, 19 Misc. 2d at 755–56.
9. *Id*.
10. *See Romar*, 120 A.D.2d at 421 (1st Dep't); *Apostolou*, 72 A.D.2d at 781 (2d Dep't).
11. N.Y.L.J., Oct. 15, 2001, p. 21, col. 1 (Sup. Ct., N.Y. Co.).
12. *Id*.
13. *Id*.
14. *Id*.
15. 190 F. Supp. 2d 629, 633 (S.D.N.Y. 2002).
16. Notably, New York is not the only jurisdiction to award future damages in lump-sum under the theory of repudiation. *See, e.g., Novick v. UnumProvident Corp.*, Civil Action No. 01-CV-258, 2001 U.S. Dist. LEXIS 9735 (E.D. Pa. July 10, 2001) (future benefits permissible under circumstances evincing a repudiation by the carrier; motion to dismiss anticipatory breach claim, denied); *Dunlap v. New York Life Ins. Co.*, 958 F. Supp. 589, 591 (M.D. Fla. 1997) (applying Florida law, motion to remand case to state court based upon alleged failure to meet the statutory damages threshold for subject-matter jurisdiction, denied owing to the lump-sum benefit demanded in the complaint; "Defendant repudiated the entire contract when it refused to continue making any payments whatsoever to Plaintiff"). *Smith v. Union Mut. Life Ins. Co.*, 726 F.2d 437, 440 (8th Cir.), *cert. denied*, 469 U.S. 981 (1984), *reh'g denied*, 469 U.S. 1143 (1985) (applying Arkansas law, appellate court reversed order granting judgment notwithstanding the verdict and awarded insured full benefits, past and future, under the policy); *National Cas. Co. v. Brundage*, 148 F.2d 687 (D.C. Cir. 1945) (insured entitled to receive present-day value of policy upon proof of repudiation); *Metropolitan Life Ins. Co. v. Harper*, 189 Ark. 170, 70 S.W.2d 1042 (Ark. 1934) (where an insurer repudiates its contractual obligation, as by denying the existence or validity of the contract, an insured entitled to disability payments is not limited in recovery to installments which have accrued up to time of suit, but may also recover the present value of future benefits); *Prudential Ins. Co. v. Ferguson*, 51 Ga. App. 341, 180 S.E. 503 (Ga. Ct. App. 1935) (remedy for repudiation of a disability insurance contract is the present-day value of future benefits); *Prudence Life Ins. Co. v. Morgan*, 138 Ind. App. 287, 306, 213 N.E.2d 900 (Ind. Ct. App. 1966) (citing Indiana and Kentucky law, the court held that the insurance carrier's effort to establish its affirmative defense of fraud in the inducement for rescission of the policy constitutes repudiation, entitling the insured to obtain the present-day value of future benefits in lump-sum); *Group Life & Health Ins. Co. v. Turner*, 620 S.W.2d 670 (Tex. Ct. App. 1981) (denial of benefits, coupled with an instruction by adjuster to stop calling for reconsideration because the carrier was not going to reconsider, constituted repudiation, entitling the insured to recover not only past benefits but future benefits in lump sum, plus attorneys' fees and a 12% penalty against the carrier).
17. *See, e.g., Pavia v. State Farm Mut. Auto. Ins. Co.*, 82 N.Y.2d 445, 605 N.Y.S.2d 208 (1993).
18. *Id*.
19. 19 N.Y.2d 519, 281 N.Y.S.2d 28 (1967).
20. *Id*. at 522.
21. *New York Marine & Gen. Ins. Co. v. Tradeline LLC*, 98 Civ. 7840, 1999 U.S. Dist. LEXIS 20022 (S.D.N.Y. Dec. 27, 1999) (in the context of first-party claim, "attorneys' fees may be awarded where there has been an unreasonable, bad faith denial of coverage"); *FDIC v. National Sur. Corp.*, 425 F. Supp. 200, 204 (E.D.N.Y. 1977) (motion to dismiss claim for attorneys' fees in first-party claim for bad faith, denied); *Pavia*, 82 N.Y.2d 445; *New England Mut. Life Ins. Co. v. Johnson*, 155 Misc. 2d 680, 589 N.Y.S.2d 736 (Sup. Ct., N.Y. Co. 1992) (damages for bad faith, granted).
22. 155 Misc. 2d 680.
23. *Id*. at 684.
24. *Id*. at 685.
25. *Wurm v. Commercial Ins. Co. of Newark, NJ*, N.Y.L.J., Oct. 15, 2001, p. 21, col. 1 (Sup. Ct., N.Y. Co.).
26. According to the decision in *Wurm*, the defendant-insurers "originally determined that [the plaintiff] was entitled to benefits under the policy" and confirmed that determination after retaining an orthopedist who similarly concluded that her injuries were totally and permanently debilitating. Nonetheless, the defendants placed her under surveillance repeatedly, attempted to convince the plaintiff to perform services in her occupation by posing as a patient, provided the insured's doctors with misleading and incomplete medical records in an effort to convince them to change their diagnoses, and otherwise pursued additional investigations to provide a "bogus basis" to deny her claims. *Id*.
27. *Acquista v. New York Life Ins. Co.*, 285 A.D.2d 73, 80–81, 730 N.Y.S.2d 272 (1st Dep't 2001).
28. *Id*. (quoting *Beck v. Farmers Ins. Exch.*, 701 P.2d 795, 801 (Utah 1985)).
29. *Acquista*, 285 A.D.2d at 79.
30. *Id.* at 81 (citations omitted).

31. *Id*. at 79.
32. *See* Brief for Plaintiff-Appellant at 27–30, *Acquista v. New York Life Ins. Co.*, 285 A.D.2d 73, 730 N.Y.S.2d 272 (1st Dep't 2001) (Plaintiff-Appellant argued entitlement to punitive damages and other relief for bad faith, but not attorneys' fees).
33. *Id*.
34. It is also possible that the First Department in *Acquista* intended to include attorneys' fees as an element of consequential damages, as other courts have done. *Canyon Country Store v. Bracey*, 781 P.2d 414, 420 (Utah 1989) (one-third contingency fee awarded to attorneys as an elemental of consequential damages); *Jordan v. National Grange Mut. Ins. Co.*, 183 W. Va. 9, 393 S.E.2d 647 (W. Va. 1990) (attorneys' fees awarded for bad faith in first-party disability case as element of compensatory damages).
35. *Standards for Limiting the Tort of Bad Faith Breach of Contract*, 16 U.S.F. L. Rev. 187, 200–201 (1982).
36. *Curry v. Fireman's Fund Ins. Co.*, 784 S.W.2d 176, 178 (Ky. 1989).
37. *Robbins v. Traveler's Ins. Co.*, 151 Misc. 151, 152, 269 N.Y.S. 841 (Sup. Ct., N.Y. Co.), *aff'd*, 241 A.D. 350, 272 N.Y.S. 551 (1st Dep't 1934).
38. *Id*. at 153.
39. *See, e.g., Egan v. Mutual of Omaha Ins. Co.*, 24 Cal. 3d 809, n.7, 620 P.2d 141 (Cal. 1979) (in cases in which the insurer engages in bad faith, "the jury may include in the compensatory damage award[,] future policy benefits that they reasonably conclude, after examination of the policy's provisions and other evidence, the policy holder would have been entitled to receive had the contract been honored by the insurer").
40. Of course, this should not prevent a carrier from enforcing the terms of the policy when its employees *reasonably* believe an insured to be sufficiently recovered to resume employment.

Use of Surveillance Evidence Poses Risk of Ethical Dilemmas And Possible Juror Backlash

By William C. Altreuter

Billy Wilder's film *The Fortune Cookie*[1] is probably the best demonstration of how *sub rosa* investigation is thought of, even today, 35 years after it was released. Jack Lemmon plays a photographer injured at a football game whose brother-in-law, a sleazy plaintiff's lawyer, concocts a bogus lawsuit out of the event. The devious defense team endeavors to catch Lemmon in his fraud, and hilarity ensues. The joke, of course, is that even though the plaintiff is not hurt and is capable of doing what he claims he can no longer do, our sympathies as an audience are with the plaintiff and against the defense—all the way.[2] This is the danger of surveillance evidence at trial: although it can be dramatic, its effectiveness can cut both ways.

The reasons for this go deeper than our love for the underdog, or even the appeal that Jack Lemmon and Walter Matthau had up until *Grumpy Old Men*.[3] The invasive tactics employed by the investigators in *The Fortune Cookie* are offensive to our sense of personal autonomy—to our belief that our privacy is a sacred right guaranteed by the Constitution, the Bill of Rights, the common law, federal and state statutes, local regulations and house rules.[4]

There is no question that film or video showing a plaintiff doing something that has been claimed cannot be done can be dramatic evidence. Developments in the way such materials are treated for discovery purposes, however, operate to diminish the effectiveness of proof that was already risky, and may tempt the unwary to overstep. Developments in the law of privacy, or at least the growing awareness of privacy law concerns, may operate to increase the potential peril of overintrusive surveillance tactics for defense counsel, their clients, and insurance companies.

Although privacy considerations have always been a concern in personal injury litigation, these interests are balanced against the right of the defendant to investigate claims and the social utility favoring exposure of fraud. To some extent, therefore, a plaintiff's expectation of privacy is diminished; but when the investigation of a claim goes beyond what is reasonable, sanctions and even tort liability may follow.[5]

The downside risk of using surveillance evidence has always been that a jury will become outraged over the intrusive tactic, and will return a verdict that punishes the defendant for being so rude as to spy on an injured plaintiff. In cases where plaintiffs are caught on film actually doing something they have claimed they cannot do, the drama can outweigh this risk, and these cases are the ones most likely lead to a decision to use surveillance evidence. Often, however, it is a close call. The point of the proof is to demonstrate that the plaintiff's claim is wholly fraudulent; and in instances where the plaintiff's claimed limitations were merely exaggerated, the subtle distinction between lying and mere hyperbole are often lost on a jury.

In *DiMichel v. South Buffalo Railway Co.*,[6] the Court of Appeals resolved a conflict among the four departments of the Appellate Division regarding the discoverability of surveillance tapes.[7] Chief Judge Wachtler noted at the outset:

> Surveillance films can serve a uniquely compelling function in a personal injury trial. They are designed to undermine, in a potentially sensational manner, a plaintiff's claims that he or she was seriously injured. At the same time, however, visual images are easily manipulated and can, as the result of skillful editing or crafty camera work, give a false depiction of a plaintiff's condition.[8]

The handwriting was on the wall with the next sentence: "Defense counsel argues that only by permitting a defendant to *spring* these films on the plaintiff at trial

William C. Altreuter is a member of Altreuter Habermehl (www.althab.com), a litigation practice with offices in Buffalo and New York City. He is a graduate of the State University of New York College at Geneseo, and the University at Buffalo School of Law, where he is now an adjunct lecturer.

will the truth-seeking function of cross-examination be safeguarded."[9]

Reasoning that trial by ambush was precisely the evil that liberal discovery rules are intended to circumvent, the Court went on to hold that the best balance between the two extremes—the possibility of fraud by plaintiffs who might lie about their disability and the possibility of "crafty" defendants manipulating images to "spring" upon the honestly injured claimants—was to require that defendants disclose only those tapes they plan to use at trial. The Court fashioned this compromise by reasoning that although surveillance materials were "material[s] prepared for litigation," plaintiffs have a substantial need for the disclosure of these materials because films are "so easily altered." The "very real danger that deceptive tapes, inadequately authenticated, could contaminate the trial process"[10] creates the need to allow for authentication by plaintiff's counsel. Cross-examination and *voir dire* were rejected as appropriate tools for this task, notwithstanding the fact that this had been the favored tactic of plaintiff's counsel before *DiMichel*, because "[a]uthentication of surveillance films can be a slow and painstaking process."[11]

The downside risk of using surveillance evidence has always been that a jury will become outraged over the intrusive tactic, and will return a verdict that punishes the defendant.

Notwithstanding this approach, the Court found that cross-examination would suffice as a truth-seeking tool for defense counsel seeking to demonstrate that a plaintiff was tailoring testimony to fit the surveillance proof. Although the tailoring of testimony was viewed as a legitimate concern, the Court found that this argument against disclosure failed to account for New York's policy of open pretrial disclosure, and that "it is persuasive only if we assume that surveillance tapes are always accurate and plaintiffs always dishonest. As noted above, however, surveillance films are extraordinarily susceptible to manipulation, and, once altered, are peculiarly dangerous."[12] The Court acknowledged that the risk of tailored testimony was real,[13] and fashioned its holding to provide that films in the possession of the defendant could be withheld until after the plaintiff's deposition had been completed.[14] Mindful of the fact that its holding amounted to a compromise necessitated by the two competing disclosure standards, the Court also held that only those surveillance materials the defendant intended to use at trial were subject to disclosure. This was significant to the outcome of *Poole v. Consolidated Rail Corp.*[15] because, in that case, plaintiff's counsel had commented on the existence of surveillance material during the course of the trial, even though the material had not been introduced or offered in evidence. This invited the jury to speculate that the material in question was favorable to the plaintiff and unfavorable to the defendant. The Court found that counsel's comments were prejudicial:

> To permit the plaintiff to profit from his knowledge of the content and existence of such tapes in this manner would enable him, by virtue of open pretrial disclosure, to engage in the sort of gamesmanship that we are seeking to discourage in the defendant. Thus, we hold as a matter of law that where surveillance films have been duly turned over to the plaintiff pursuant to our decision today, and the defendant decides subsequently, as a matter of trial strategy, not to use such films at trial, plaintiff cannot turn this strategy to his or her advantage and comment on this decision to the jury.[16]

Notably, in reaching its conclusions the Court did not see that it was necessary to find that surveillance films were somehow "party statements." This argument, which seems conceptually strained, contains the seeds for an abundance of mischief. Would an investigator observing a plaintiff playing a game of H-O-R-S-E in his driveway be "interviewing" the plaintiff? Since the investigator is an agent of the defendant's counsel, would such observations amount to improper *ex parte* contact? As discussed below, such considerations are relevant when considering just how intrusive investigations may be when viewed against privacy considerations.[17]

Within a year of the *DiMichel* decision, the legislature enacted CPLR 3101(i), amending CPLR 3101 to specifically address the disclosure of surveillance material. CPLR 3101(i) provides:

> In addition to any other matter which may be subject to disclosure, there shall be full disclosure of any films, photographs, video tapes or audio tapes, including transcripts or memoranda thereof, involving a person referred to in paragraph one of subdivision (a) of this section. There shall be disclosure of all portions of such material, including out-takes, rather than only those portions a party intends to use.

On its face, CPLR 3101(i) represents a broadening of the disclosure requirements enunciated in *DiMichel.* All surveillance materials are to be disclosed, not merely those the defendant intends to use; and, in *Di Nardo v. Koronowski*,[18] the Appellate Division held that, inasmuch as the statute was silent on the question of the timing of disclosure, disclosure was to be made "upon demand."

The first effect of *Di Nardo* may have been in the timing of the decision to conduct a *sub rosa* investigation of a plaintiff. Because surveillance materials are disclosable upon demand, they must be surrendered, if they exist, in advance of the plaintiff's deposition. The danger of tailored testimony, which the Court of Appeals had found to be "real," was apparently a peril that the legislature found chimerical. As a purely practical matter, surveillance is, in the post-*Di Nardo* world, ordered after depositions have been conducted. This means that deposition testimony specifically targeted to particular activities is more difficult to develop, and may have an impact on the overall effectiveness of the surveillance proof in a given case, because it is now more difficult to catch a prevaricating plaintiff in an outright lie.

Decisions in the Third and Fourth Departments since *Di Nardo* have evidenced a sort of "zero tolerance" for dilatory disclosure, although a new split among the Appellate Divisions has developed. In *Barrowman v. Niagara Mohawk Power Corp.*,[19] the Appellate Division affirmed the trial court's order precluding the defendant from introducing surveillance evidence upon discovering that the defendant had falsely represented that complete disclosure had been made. In *Young v. Knickerbocker Arena*,[20] the Third Department precluded the defendant from introducing surveillance evidence due to an unexplained five-month failure to disclose the video in question.[21]

The fact that the sanction employed in each of these cases was preclusion of the surveillance proof suggests that the defendant sought to introduce the film or video in question: obviously, preclusion would not be a meaningful sanction if the defendant did not intend to use the proof at trial. Inasmuch as the inflammatory nature of surveillance proof generally makes defense counsel reluctant to employ it unless it unambiguously demonstrates that the plaintiff is not disabled, the evidence in question was almost certainly "devastating," as Judge Wachtler expressed it in *DiMichel.* Precluding such proof evinces the strong distaste the courts seem to have developed for surveillance evidence, even in cases where it is extremely probative.

Most recently, the First Department has reentered the fray, and expressly declined to follow the rule enunciated in *Di Nardo*.[22] In *Tran v. New Rochelle Hospital Medical Center*,[23] the court reversed the decision of the IAS Court and directed that the plaintiff be produced for deposition before disclosure of surveillance materials. The Fourth Department viewed the question as one of statutory construction: because CPLR 3101(i) was silent on the question, the discovery is owed on demand. The First Department in *Tran* took a somewhat broader view:

> Clearly, the *DiMichel* decision was the impetus for the CPLR amendment, but there are no legislative memoranda indicating an intent to "supersede" the entirety of that decision. CPLR 3101(i) does expand the scope of the discovery to which the plaintiff is entitled, but it fails to address the question at the crux of this appeal, which the Court of Appeals specifically confronted in *DiMichel*, namely, the order of priority in disclosing the video materials.[24]

The court found that concern over "sandbagging or trial by ambush" was not warranted, because, "plaintiffs are already fortified with the knowledge of the *existence* of video surveillance materials."[25] The court went on to assert that the rule followed in the Third and Fourth Departments "is based upon a misconception of the scope of CPLR 3101(i), which is silent on the priority issue presented here, and ignores the application of CPLR 3106(a), which accords the normal priority in discovery to defendants."[26]

CPLR 3101(i) and *Di Nardo* inject into the already complicated calculation of whether to conduct surveillance of a plaintiff the requirement of complete disclosure of the materials generated thereby. At a minimum, this creates the possibility that the plaintiff may decide to use the materials. Several tactical reasons for so doing suggest themselves. If the surveillance corroborates the plaintiff's claimed disability, defense counsel will have, in effect, produced a "day in the life" film for the plaintiff—a powerful piece of demonstrative evidence—financed by the defendant. The plaintiff is free to offer this proof, and once its source is made known to a jury it is likely to reflect badly on the defendant. As discussed above, surveillance proof that is not devastating to the plaintiff's case is usually very damaging to the defendant's image, and this can show up in the verdict. A defendant perceived as being "bad" in addition to being negligent will often find that it is punished in a jury's verdict, whether because it does not receive the benefit of the doubt on any close questions, or simply because its conduct is viewed as being aggravated or more egregious due to the privacy invasion represented by its surveillance.

In *DiMichel*, the Court noted that "defendants secure surveillance materials in order to verify the extent of a plaintiff's purported injuries and introduce them because they are powerful and immediate images that cast doubt upon the plaintiff's claims."[27] Experienced defense counsel have seen hours of surveillance footage, and often it established the plaintiff's claim more effectively than any other proof. In such instances the surveillance proof often acted as an effective inducement towards settlement. The film or video could be played for skeptical clients or insurance company representatives, and used as a basis for a recommendation not to proceed to trial.

This twofold function—verification and demonstration—is eliminated under the *Di Nardo* holding, although the First Department seems to acknowledge its utility by observing that the knowledge of surveillance material operates to limit the extent to which a plaintiff may tailor her testimony. Surveillance evidence after *DiMichel* is principally demonstrative proof, however, and this invites abuse.

Shadowing Tactics

So-called "rough shadowing" techniques, designed to produce the sought-after results are described in George A. LaMarca's 1985 article, "Overintrusive Surveillance of Plaintiffs in Personal Injury Cases."[28] Mr. LaMarca sets out an interesting catalogue of tactics.

Withholding surveillance proof is a dangerous tactic: the truth will come out at some point, and counsel should be wary of making false representations.

One technique is known as "duping the subject." A typical situation that involves duping would begin by establishing that a plaintiff frequents a particular establishment and instructing an investigator to strike up an acquaintance. What generally follows is some sort of setup whereby the "duped" plaintiff is enticed to engage in certain activities that are filmed, revealing the extent of the physical activity or injuries. For example, having gained the plaintiff's confidence and friendship, an investigator takes the plaintiff to an amusement park and has her or him walk across an expansion bridge, which the investigator causes to shake and sway in an attempt to detect the extent of the injuries. While this activity is under way, another investigator is taking motion pictures. This particular activity has been ruled by some courts as so beyond reasonability that it subjects the investigators to an action for damages for intrusive and willful conduct.

"Roping" is a manufactured setting designed to encourage physical activity. Typically, the plaintiff, out of work because of the injury and thus in need of funds, is offered temporary work such as planting shrubbery or raking leaves. The work usually is done at a location where the plaintiff's physical activities can be photographed over a two- or three-day period. Generally the plaintiff is offered attractive hourly wages that would be hard to refuse. Again, this technique, which includes deception and misrepresentation, might result in a finding of an unreasonable investigation by courts.

Aggravating the subject into a "statement of activity" is another technique. The object is to obtain motion pictures of the plaintiff performing a strenuous activity such as changing the tire on a car. Because a flat tire is a relatively rare occurrence, the surveillance team intentionally deflates the plaintiff's tire, conceals itself, then films the plaintiff's activities. Techniques employed to cause the plaintiff's tire to go flat include using a valve cap with a long inverted nipple that loosens the core of the tire valve, puncturing the tire with a sharp instrument, or firing a pellet gun at the tire. This approach gives the investigators information on the plaintiff's physical abilities, but it may open the investigator to liability for trespass, vandalism, and property damage.

A technique called the "mess" involves some form of sticky rubbish, usually a mixture of flour, plaster-of-paris, shellac, ink and the like. The investigators throw this mixture on the windshield of the plaintiff's automobile. This draws the plaintiff into the open to clean it, giving the investigator a good view from which to take still or motion pictures of the plaintiff's particular capabilities in a near-normal situation.

The "delivery" is a technique whereby the investigator contrives to obstruct the driveway, porch, or similar necessary access area at the plaintiff's home. The investigator might telephone a building supply firm while the plaintiff is off the premises and, in the plaintiff's name, order several pounds of sand or some other object that is left in a place where the plaintiff must remove it immediately upon arriving home. At this point, the investigator is positioned to film the activities involved in removing the object.[29]

Sanctions

All of these tactics have been found to constitute tortious invasions of privacy in jurisdictions other than New York, but in New York, where there is no common law right of privacy,[30] some creativity would be called for if these practices were to be held actionable. For example, in *Dana v. Oak Park Marina*[31]and its companion *Mastro v. Oak Park Marina*,[32] the Appellate Division upheld causes of action for reckless infliction of mental and emotional distress in litigation arising from the installation of video surveillance cameras in the rest rooms and office area of a marina, purportedly for the purposes of detecting and curbing vandalism and theft. The elements of this tort, "(i) extreme and outrageous conduct; (ii) intent to cause, *or disregard of a substantial probability of causing,* severe emotional distress; (iii) a causal connection between the conduct and injury; and (iv) severe emotional distress"[33] could, without much of a reach, apply to any of the tactics described above.

It is more probable, however, given the dislike the courts have evinced for surveillance proof, that overzealous tactics will be punished with sanctions beyond

merely precluding the film or video from being introduced at trial. Monetary sanctions, or even the striking of the defendant's answer are remedies available under CPLR 3126. Withholding surveillance proof is a dangerous tactic: the truth will come out at some point, and counsel should be wary of making false representations. The standard for disclosure is that requested items shall be exchanged if counsel knows, or *should* know, of the existence of items responsive to a demand. Counsel would be well advised to make sure that the insurance professionals with whom they are working, and their investigative personnel, are aware of the disclosure requirements to avoid the possibility of surveillance proof surfacing in a way that invites judicial sanctions. Viewed in this context, the rule adopted by the First Department in *Tran* certainly seems more likely to diminish the incentives for abuse, whether advertent or inadvertent.

The ultimate sanction manifests itself in the ire of a jury. Surveillance proof, once disclosed, is highly vulnerable to testimony from the plaintiff, detailing how the events depicted represented an unusual instance, and how the aftermath of the momentary event displayed was hours, days or weeks of additional pain. Juries receive this type of testimony sympathetically, and readily accept the argument that the plaintiff has been twice violated: by the event underlying the lawsuit, and by the intrusive spying of the defendant's lawyers and investigators and insurers. The defense in a personal injury lawsuit is often depicted as bringing vast resources to bear against the claimant; surveillance proof underlines this perception.

The decision to undertake surveillance of a plaintiff in a personal injury lawsuit has always been a complicated issue for defense counsel, if only because of the expense involved. As the law has developed, it is now plain that this type of proof is probably best used only after more discreet forms of background investigation, together with thorough discovery and depositions, have led to the conclusion that a claim is demonstrably fraudulent. *The Fortune Cookie* is a historical artifact that will shortly resemble the way personal injury defense is conducted in the way that *My Cousin Vinny*[34] resembles a typical criminal trial.

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1. MGM 1966. Jack Lemmon, Walter Matthau, Ron Rich, Cliff Osmond, Judi West. Directed by Billy Wilder. Written by Billy Wilder and I.A.L. Diamond. Produced by Billy Wilder.
2. A possible exception to this cinematic general rule may be *The Verdict*, the 1982 Paul Newman vehicle. (20th Century Fox. Directed by Sidney Lumet, screenplay by David Mamet; also featuring James Mason, Jack Warden and Charlotte Rampling.) Newman's character engages in a variety of intrusive and unethical investigative tactics, including breaking into a mailbox. The underhanded tactics of defense counsel include prying into the attorney-client relation by placing a "mole" (Rampling) in Newman's office. The fact that defense counsel is portrayed as being unethical, combined with Newman's Academy Award nominated performance (and Newman's appeal generally) no doubt accounts for the ability of the audience to accept the intrusive conduct depicted.
3. Warner Brothers, 1993. Directed by Donald Petrie. Screenplay by Mark Steven Johnson. Also featuring Ann-Margaret, Burgess Meredith, Ossie Davis, Kevin Pollack, and Daryl Hannah.
4. George A. LaMarca, *Overintrusive Surveillance of Plaintiffs in Personal Injury Cases*, 9 Am. J. Trial Advoc. 1 (1985).
5. *Evans v. Anheuser-Busch, Inc.*, 277 A.D.2d 874, 716 N.Y.S.2d 268 (4th Dep't 2000).
6. 80 N.Y.2d 184, 590 N.Y.S.2d 1 (1992).
7. It is not clear why the Fourth Department is such a hotbed for this sort of litigation, but it's not just Buffalo: *Evans*, 277 A.D.2d 874, is a Syracuse case.
8. 80 N.Y.2d at 190. In *Marte v. W.O. Hickok Mfg. Co.*, 154 A.D.2d 173, 552 N.Y.S.2d 297 (1st Dep't 1990), the First Department found that surveillance films should be discoverable in their entirety pursuant to CPLR 3101(e), which governs party statements. The Fourth Department in *DiMichel v. South Buffalo Ry. Co.*, 178 A.D.2d 914, 579 N.Y.S.2d 788 (4th Dep't 1991) and *Poole v. Consolidated Rail Corp.*, 178 A.D.2d 941, 579 N.Y.S.2d 772 (4th Dep't 1991), treated surveillance films as material prepared for litigation and held that such films were discoverable because they could not be reproduced by other means, and were susceptible to manipulation. In *Careccia v. Enstrom*, 174 A.D.2d 48, 578 N.Y.S.2d 678 (3d Dep't 1992), the Third Department agreed with the Fourth Department that surveillance tapes were not party statements for purposes of CPLR 3101(e), but were instead material prepared for litigation under CPLR 3101(d)(2). The court held that surveillance tapes were analogous to the statements and reports of an investigator hired by defendant to observe plaintiff's activities, and rejected the Fourth Department's holding in *DiMichel*, ruling instead that authenticity could be verified through *voir dire* and cross-examination of the person who had made the videotape. In *Kane v. Her-Pet Refrigeration Co.*, 181 A.D.2d 257, 587 N.Y.S.2d 339 (2d Dep't 1992), the Second Department agreed with the holding in *DiMichel*, and found that although surveillance films were material prepared for litigation, they should be subject to disclosure because of "the plaintiffs' substantial need to verify the accuracy of the potentially devastating films prior to trial."
9. *DiMichel,* 80 N.Y.2d at 190 (emphasis added).
10. *Id.* at 196.
11. *Id.*
12. *Id.* at 197.
13. *Id.*
14. *Id.* No authority was given as an example of this "very real danger." One of the tactical questions which used to be confronted by defense counsel contemplating the use of surveillance film was what, out of *x* amount of film taken, should be displayed to the jury? Showing clips of highlights, and editing out the more mundane activities of the plaintiff, or even editing out footage which might tend to corroborate the plaintiff's claimed injury, could be very effectively countered by plaintiff's counsel cross-examining the investigator who took the films on the question of how much additional footage existed, or by show-

ing all of the footage, numbing the jury to the damaging few seconds shown by the defense. The Court found that this approach might not be sufficient: "Even if after careful examination plaintiff was able to demonstrate that the evidence had indeed been distorted, it would be difficult to undo its initial impact and to erase the impression left in the minds of the jury members." *Id*. at 196.

15. 178 A.D.2d 941, 579 N.Y.S.2d 772 (4th Dep't 1991), *rev'd sub nom*. *DiMichel v. South Buffalo Ry. Co.*, 80 N.Y.2d 184, 590 N.Y.S.2d 1 (1992).
16. *DiMichel*, 80 N.Y.2d at 199.
17. Although *DiMichel* represented a shift in the law of New York, it was foreshadowed by a number of decisions in other jurisdictions, and in decisions interpreting the disclosure requirements under the Federal Rules of Civil Procedure. *See, e.g.*, *Martin v. Long Island R.R. Co.*, 63 F.R.D. 53 (E.D.N.Y. 1974).
18. 252 A.D.2d 69, 684 N.Y.S.2d 736 (4th Dep't 1998).
19. 252 A.D.2d 946, 675 N.Y.S.2d 734 (4th Dep't), *appeal denied*, 92 N.Y.2d 817, 684 N.Y.S.2d 488 (1998).
20. 281 A.D.2d 761, 722 N.Y.S.2d 596 (3d Dep't 2001).
21. *See Evans v. Anheuser-Busch, Inc.*, 277 A.D.2d 874, 716 N.Y.S.2d 268 (4th Dep't 2000).
22. The First Department declined to reach the question in *Bojkovic v. JLT Assocs.*, 278 A.D.2d 46, 717 N.Y.S.2d 171 (1st Dep't 2000) because of plaintiff's failure to timely file an appeal or cross-appeal.
23. 291 A.D.2d 121, 740 N.Y.S.2d 11 (1st Dep't 2002).
24. *Id*. at 124.
25. *Id*. at 125.
26. *Id*.
27. *DiMichel v. South Buffalo Ry. Co.*, 80 N.Y.2d 184, 193, 590 N.Y.S.2d 1 (1992).
28. LaMarca, *supra* note 4.
29. *Id*. at 6–9.
30. *Howell v. New York Post Co.*, 81 N.Y.2d 115, 596 N.Y.S.2d 350 (1993) ("There is, of course, no cause of action in this State for publication of truthful but embarrassing facts.").
31. 230 A.D.2d 204, 660 N.Y.S.2d 906 (4th Dep't 1997).
32. 238 A.D.2d 930, 661 N.Y.S.2d 554 (4th Dep't 1997).
33. *Dana*, 230 A.D.2d at 209 (quoting *Howell*, 81 N.Y.2d at 121).
34. Trimark, 1992. Directed by Jonathan Lynn; featuring Joe Pesci, Ralph Macchio, Mitchell Whitfield, Marisa Tomei, Fred Gwynne and Lane Smith.

Behavioral Decision Theory Can Offer New Dimension To Legal Analysis of Motivations

By Paul Bennett Marrow

Many lawyers and judges dismiss the application of cognitive psychology to the practicalities of the law on the grounds that it represents nothing more than fuzzy science. This may be a serious mistake. Cognitive psychology has a place in our judicial system, and attorneys discovering this are bringing a new dimension to their legal analysis.

Behavioral Decision Theory or BDT may have application in situations where the decision-making process is being scrutinized. BDT can be used to better understand how and why people reach decisions, and how others may seek to influence how these decisions are made. Seem a bit abstract and perhaps irrelevant? Think again, especially about situations that involve an assumption of a risk. A case in point: tobacco litigation. Those attacking the tobacco industry were able to show, in part by using the principles of BDT, that Joe Camel was intentionally designed to appeal to known cognitive weaknesses and to override information provided to potential smokers that tobacco is a very dangerous drug. The tobacco industry had no other way to account for Joe Camel, and the rest is history.[1]

Until BDT came on the scene, lawyers and judges assumed that when people make decisions involving serious matters like the assumption of any risk, they do so in a rational manner. This changed when cognitive psychologists began a line of inquiry that provided empirical evidence establishing that, indeed, people sometimes are irrational in their decision-making process. Of course, if BDT established only that people can be irrational, we would all yawn and dismiss the research as merely confirming the obvious. But suppose it can be shown that someone has knowingly manipulated this propensity and that in doing so has taken unfair advantage of someone else. If BDT can be used to establish that the decision maker was tricked into ignoring his or her own better judgment and that the result was detrimental, BDT becomes a very useful tool indeed.

Improper manipulation isn't the same as fraud or false advertising. It involves a conscious attempt to thwart rational decision making by disarming the decision maker and overriding good judgment. Sometimes manipulation is acceptable, such as when the manipulated party ends up doing no more than he or she originally intended to do. A consumer who intended to purchase soap can be manipulated to prefer brand A over brand B and is no worse for the manipulation. But when manipulation is designed to thwart good judgment to the detriment of the decision maker, things change. BDT offers a new level of circumstantial evidence about what might actually be going on. Such was the case with Joe Camel. The tobacco industry couldn't account for that manipulation, and thereby left open the door for juries to conclude that big tobacco was up to something nefarious.

Another example: situations where the manipulation is of trust. One commentator has detailed the application of BDT to the obligation of a customer to read disclosure materials provided by a stockbroker.[2] If the stockbroker manipulates the customer intending to create the impression that the customer can trust the stockbroker to review disclosure materials on the customer's behalf, that manipulation should preclude the stockbroker from later attempting to take advantage of the customer's failure to have actually read such materials.

Filters That Affect Ability to See Clearly

People make decisions using filters that yield cognitive distortions, errors and illusions and sometimes these errors are systemic. There are two types of filters: effects and biases.

Effects Effects have to do with the context in which a decision is made. There are many, and but a few examples illustrate the principle.

Paul Bennett Marrow serves as counsel to Banks, Shapiro, Gettinger, Waldinger & Brennan in Mt. Kisco. He graduated from Case Western Reserve University and received his J.D. degree from New York Law School.

• Endowment effect: People will often place a higher value on something they already have than on the same thing if it belongs to someone else. The effect represents a resistance to parting with something, not an increase in its value to the owner. In one experiment, subjects were asked to imagine owning a coffee mug and then asked to predict a selling price. They were then given a coffee mug and asked what they would want to sell it for. Before receiving the mug, the average estimated selling price was $3.73. Once they had received the mug, the average price jumped to $5.40. This phenomenon can be manipulated, *i.e.*, the perception of being or not being endowed can be positioned to influence a willingness to part with or retain the perceived endowment.[3]

• Framing: As we all know, people are both risk-tolerant and risk-averse. Framing assists in determining how risk is viewed and how it is ultimately embraced or repudiated. Consider negotiations surrounding a liquidated damage clause that specifies a nominal amount in the event of default. Such a clause has to do with the promisor's performance and the promisee's wish that the promisor actually performs. Rejection of a demand for limitation leaves the promisee in an unacceptable position, *i.e.*, not winning the promisee's commitment to perform. Therefore, the framing of the choice creates an opportunity to have performance with a limitation or, in the alternative, no performance. The promisee is more likely to accept the limitation because of the framing effect even though that choice is arguably the riskier alternative.

Improper manipulation . . . involves a conscious attempt to thwart rational decision making by disarming the decision maker and overriding good judgment.

• Extremeness aversion: People are also adverse to extremes. Whether something is perceived as an extreme depends in large part on the position of the choice relative to others. In one experiment, subjects were asked if they preferred a less expensive and smaller radio, choice A, to a more expensive and larger radio, choice B. The subjects preferred choice A. But when the same subjects were given an additional choice, a very expensive and large radio, choice C, many who had previously selected choice A changed their minds and asked for choice B.[4] If a choice is positioned as an extreme, it is less likely to be accepted not because of the contents but because of the setting. But if it is positioned as a compromise, there is a far greater likelihood that it will be accepted.

• Illusion of control: People have a tendency to treat chance events as if they involve skill and hence are within their control. In one experiment, students stated that they were better or worse than the average person at predicting the outcome of a coin toss. The researchers provided rigged feedback on predictions and convinced the subjects that luck wasn't involved but rather that the subjects were good or bad predictors. Moreover, the same subjects reported that they were sure that their performance would improve with practice! By appealing to the desire to control, a skillful negotiator can oftentimes win acceptance of an element of a deal if the other party concludes that the element was his or her idea in the first place.

• Affect: Early studies showed that the perception of risk and the response to it are linked to the degree to which the hazardous event evokes feelings of dread. Later studies have shown that judgments about risk and benefit are negatively correlated.[5] The greater the perceived benefit, the lower the perceived risk, and vice versa, suggesting that there is an inverse relationship between perceived risk and perceived benefit linked to the strength of positive and negative emotion associated with an event. This implies that people base their judgments not only on how they think about something but how they *feel* about it. Affect therefore acts as a filter through which risk is perceived and evaluated.

Biases Biases are about how people evaluate and utilize information. We all have limitations on our ability to understand and handle information. This limitation is known as "bounded rationality."[6] People tend to set an initial target level of aspiration or satisfaction, and once that target has been met, they terminate the search for an alternative. Once information is received that is good enough to meet the established expectation, consideration of alternatives is abandoned. This is called "satisficing."[7]

There are many types of biases; the following are only a few examples.

• Overconfidence: Oftentimes people tend to be overconfident with respect to future events, even when they understand the rather negative actuarial probabilities of such events. This is because people tend to use past positive experience as the foundation for predicting the future, resulting in an underestimation of risk. Overconfidence creates a resistance to information that suggests the need for caution and can be manipulated to disarm an individual considering the assumption of a risk.

• Cognitive dissonance: Cognitive dissonance is a tendency to repudiate or downplay information that

contradicts more favorable information about oneself. In the face of known risk, some might develop an opinion that they themselves are relatively immune from the consequences of the risk, thereby dangerously undervaluing a risk because of a misplaced trust in their own beliefs. This can become particularly acute where there are repeat reinforcements of the misplaced trust. Therefore, it behooves the person seeking to lay off risk to present it in such a manner that it resembles previously encountered risks.

• Cooperation: In an ordered society, people generally seek to cooperate and act fairly. Sometimes they will sacrifice self-interest either to cooperate or to appear to be cooperating. Constructive confrontation may even be avoided for fear that it will be perceived as non-cooperation. This bias can be easily manipulated by techniques that position confrontation as an expression of non-cooperation.

• Anchoring and adjustment: When people undertake to estimate the possibility of a future event happening, they frequently "anchor" onto some initial possibility and then fail to adjust carefully when new information becomes available. If the initial anchor is to an arbitrary or nonrational perception, systematic errors can appear because the initial value was skewed. This bias, too, can be easily manipulated by using the framing effect to trigger anchoring to a misconception or to a pre-established reference point.

• Status quo bias: Preferences of a decision maker can depend on how that person perceives options relative to the status quo. If given a choice between options that represent deviations from the status quo, people will tend to gravitate towards the option that represents the least deviation. If someone perceives a deviation from the status quo, there is a likelihood that the individual will accept or reject terms on that basis without a clear understanding of what the implications of the terms really are.

Tying It All Together

With contracts that involve claims of unconscionability, BDT can be used to show ambient circumstances which suggest an intention to disarm perceptions about the assumption of a risk, thereby gaining an unfair advantage.[8]

Sales techniques are sometimes knowingly designed to create the impression that a relationship of trust exists, when, of course, it really doesn't, and that this in turn triggers known biases such as the cooperation bias, cognitive dissonance and the overconfidence bias, which collectively cause the decision maker to underestimate risk, to his or her detriment. Certainly people are responsible for the decisions they make. But where it can be shown that, because of an intentional manipulation of the ability to evaluate the circumstances clearly, the decision maker has made an awful mistake, there is room for an exception[9] especially in a non-regulatory environment. BDT can help to smoke out whether a given situation involves an unfair and intentional manipulation.

BDT gives additional clarity about motivation, and because this knowledge may prove powerful in many situations, the practitioner is well served by learning more about BDT.

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1. *See* Jon D. Hanson & Douglas A. Kysar, *Taking Behaviorism Seriously: Some Evidence of Market Manipulation*, 112 Harv. L. Rev. 1423, 1467–1550 (1999).
2. Langevoort, *Selling Hope, Selling Risk: Some Lessons for Law from Behavioral Economics about Stock Brokers and Sophisticated Customers*, 84 Cal. L. Rev. 627 (1996).
3. Hahneman & Tversky, *Choices, Values and Frames*, 39 Am. Psychologist, 341, 348 (1984).
4. Kelman et al., *Context Dependence in Legal Decision Making*, 25 J. Legal Stud. 287, 288 (1996).
5. Alhakami & Slovic, *A Psychological Study of the Inverse Relationship Between Perceived Risk and Perceived Benefit*, 14 Risk Analysis 1085 (1994).
6. Larry T. Garvin, *Adequate Assurance of Performance: Of Risk, Duress, and Cognition*, 69 U. Col. L. Rev. 71, 141, nn.324–26 (1998).
7. Simon, *Rational Decision Making in Business Organizations*, 69 Am. Econ. Rev. 493, 502–503 (1979).
8. Paul Bennett Marrow, *The Unconscionability of a Liquidated Damage Clause: A Practical Application of Behavioral Decision Theory*, 22 Pace L. Rev. 27 (2002).
9. *See Halprin v. 2 Fifth Ave. Co.*, 101 Misc. 2d 943, 422 N.Y.S.2d 275 (Sup. Ct., N.Y. Co. 1979), *rev'd*, 75 A.D.2d 565, 427 N.Y.S.2d 258 (1st Dep't 1980), *aff'd*, 55 N.Y.2d 937, 449 N.Y.S.2d 175 (1982).

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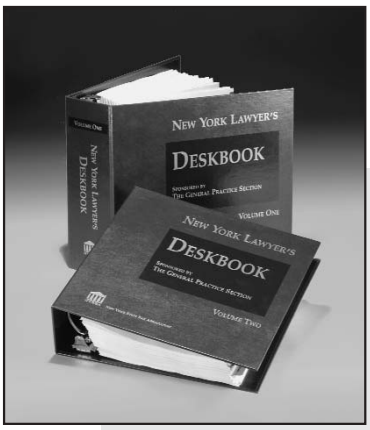

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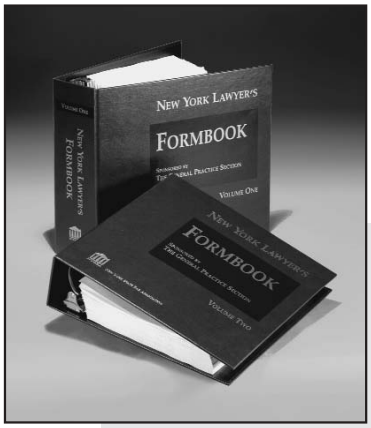

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Modern Legal Drafting, A Guide to Using Clearer Language, by Peter Butt, Esq., Solicitor, Australia; and Richard Castle, Esq., Solicitor, England and Wales; New York: Cambridge University Press, 2001, 181 pages, $60 hardcover, $23 paper. Reviewed by Eugene C. Gerhart.

On page 4 of this painstakingly researched work, the authors state, "Our purpose in this book is to encourage legal drafters to write in modern, standard English by illustrating why it is preferable to traditional legal English." Their joint effort goes a long way toward achieving their goal, thanks to their own long experience in legal practice and research.

In several sections the book covers these subjects: "What Influences the Legal Drafter," "How Legal Documents Are Interpreted," "The Move towards Modern English in Legal Drafting," "Some Benefits of Drafting in Plain English," "What to Avoid when Drafting Modern Documents," "How to Draft Modern Documents," and "Using the Modern Style."

By using common legal examples such as agreements, deeds, leases, wills, *etc*.; the authors illustrate how clarity can be achieved. Young writers can profit by their wise advice.

The phrase "modern, standard English" is defined (page 129) as "standard English as currently used and understood." Examples illustrate their goals.

Lawyers and judges in the United States, Britain, Australia and other English-speaking countries often criticize their legal brethren for many of the faults the authors point out, including intentional vagueness, "and/or" constructions, gender neutrality, "jointly and severally," and other well-known phrases. Lawyers use form books and they fear making mistakes. One reason for following a beaten path is that it leads someplace. Lawyers know that. The Bible (Eccl. 5:2-3) advises, "Let thy words be few . . . a fool's voice is known by a multitude of words." The problem is not new, and will probably not disappear soon.

Will Rogers humorously observed that "Lawyers make a living out of trying to figure out what other lawyers have written." It is true that with words we govern men [and women!], as Disraeli wisely observed. Those who use words should choose clear, succinct and forceful language.

Drafters, judges, lawyers, students and writers will profit by a study of this book. The legal profession owes the authors a debt of gratitude for a book that would be a useful and valuable addition to any legal library.

Eugene C. Gerhart is editor emeritus of the *Journal*.

Arbitration: Essential Concepts, by Steven C. Bennett, ALM Publishing, 2002, 300 pages, $32.95 paper. Reviewed by Beverly M. Poppell.

Rare is the legal treatise whose words need not be read twice to comprehend their meaning. Steven C. Bennett, has written a practical guide to arbitration that lawyers, law students and business people will find eminently useful—and readable. Written in self-contained paragraphs and chapters, *Arbitration: Essential Concepts* can be used as a quick reference for the seasoned practitioner or as a text book for those who need to learn about arbitration "from scratch."

From the particulars of constructing an arbitration clause to confirming and vacating arbitration awards, Bennett lays out practical considerations of both substance and procedure, covering, for example, how broadly or narrowly an arbitration clause should be drafted, how the arbitrator should be chosen, how the award will be enforced, how preliminary relief will be handled, what remedial powers should the arbitrator have, and what level of judicial review will be specified.

He describes the contractual nature of arbitration, emphasizing the source of the arbitrator's authority as that granted by parties themselves. He discusses the principle of separability of the agreement to arbitrate from the agreement giving rise to the dispute in the first place. A claim that an agreement to arbitrate was based on fraud, duress or other grounds may void the arbitration agreement without voiding the entire contract in which the arbitration clause is contained. On the other hand, an agreement to arbitrate may be found to exist on the basis of an exchange of correspondence expressing an intent to resolve disputes through this means.

He notes early experience with arbitration as an alternative dispute resolution technique and, pulling no punches, describes the legal and judicial communities' skepticism of the ability of arbitrators to perform that role, which the courts have jealously guarded. Tracing the U.S. Supreme Court's early reluctance to permit federal claims—particularly those arising from securities laws—to be submitted to arbitration, even on consent of the parties, Bennett succinctly describes the Court's change of heart some 30 years later to acknowledging that public policy does not preclude arbitration involving important federal rights, including those arising from securities laws as well as antitrust and RICO statutes. He points out, however, that the law continues to evolve with respect to what disputes can be put to the test in arbitration and which cannot, for public policy reasons. Criminal matters, child custody disputes and bankruptcy are three areas, Bennett notes, for which current public policy eschews arbitration.

In addition to explaining federal (Federal Arbitration Act) and parallel, state, statutory authority to arbitrate,

Bennett provides a look at the rules of sponsoring organizations that administer dispute resolution programs, such as the American Arbitration Association (U.S.), London Court of International Arbitration (London), and the International Chamber of Commerce (Paris). He reviews the rules of specialized organizations such as the National Association of Securities Dealers and paints a clear picture of different philosophies toward arbitration that commercial dealings, particularly international transactions, often reveal. For example, European arbitrators are much less tolerant of wide-ranging requests for documents and extensive examination of witnesses than are American arbitrators.

Within the American legal system, Bennett explains some of the "novel concepts and problems" posed by labor, employment, consumer and securities arbitration. For example, where employer and employees are bound by collective bargaining agreement to deal with each other over a long period of time, arbitration has proven to be a quick method of resolving contract disputes allowing the parties to mitigate the risk of labor unrest that could be occasioned by lengthy court litigation.

Bennett explains that the coverage of the federal arbitration statute is not limited to commercial contracts but extends to arbitration provisions in employment contracts that are not purely intrastate in scope. Bennett further explains that, because the Federal Arbitration Act "generally preempts inconsistent state legislation, a state probably could not enact a statute aimed at invalidating or restricting the enforceability of employment arbitration agreements." As for systems in which the employer chooses the arbitrator or where arbitration is so expensive that the employee is in effect prohibited from asserting a claim, Bennett points out that courts in some instances have invalidated such systems.

In consumer litigation, arbitration enables manufacturers, distributors and other businesses to control the risks that large jury verdicts and class actions can create in civil litigation, Bennett explains. He estimates that the increasing popularity of the Internet and electronic transactions magnify the likelihood of worldwide litigation when a consumer problem arises, and suggests that arbitration can reduce this risk by fixing a single set of procedures and venue for the resolution of such disputes.

Bennett's review of the American Arbitration Association's commercial arbitration rules is thorough but manages to avoid being tedious. He looks at typical arbitration clauses, pleadings, method of selection of an arbitrator or arbitration panel, discovery and evidence, the hearing itself, the award, arbitrator immunity and fees. His review of governing ethics and rules of professional responsibility are obligatory inclusions and are helpful, particularly for the uninitiated who may be uncertain about what to expect in their first arbitration.

Perhaps most interesting is Bennett's take on international arbitration. It is the course of commercial dealing and standards of practice, rather than legalistic rules, that have resulted in a consensus on certain core principles that guide procedures in international arbitration. One is that documentary evidence is the primary source of information used to resolve international disputes; another is that the proponent of a discovery request must make some showing that the documents exist, that the adversary possesses them, and that they are necessary for the arbitrator to decide the case.

In this country, limitations on discovery are one reason parties may choose not to arbitrate disputes. Others include the relaxed standards for decisions, limited review of the arbitration award, and difficulty acquiring preliminary relief. But as Bennett points out, many parties do not arbitrate simply because it has not been presented to them as an alternative to costly, lengthy, civil litigation. Although not a panacea, Bennett contends, arbitration serves an important role in the American decision-making system. He observes that judges, legislators, practitioners and academics are increasingly paying attention. Their effort in that regard will be aided by his straightforward writing style in this informative yet highly readable book.

Beverly M. Poppell is an attorney who serves as a labor relations neutral in New York City and writes on legal subjects.

Foundation Memorials

A fitting and lasting tribute to a deceased lawyer can be made through a memorial contribution to The New York Bar Foundation. This highly appropriate and meaningful gesture on the part of friends and associates will be felt and appreciated by the family of the deceased.

Contributions may be made to The New York Bar Foundation, One Elk Street, Albany, New York 12207, stating in whose memory it is made. An officer of the Foundation will notify the family that a contribution has been made and by whom, although the amount of the contribution will not be specified.

All lawyers in whose name contributions are made will be listed in a Foundation Memorial Book maintained at the New York State Bar Center in Albany. In addition, the names of deceased members in whose memory bequests or contributions in the sum of $1,000 or more are made will be permanently inscribed on a bronze plaque mounted in the Memorial Hall facing the handsome courtyard at the Bar Center.

Professionalism Award

An Exemplary Lawyer

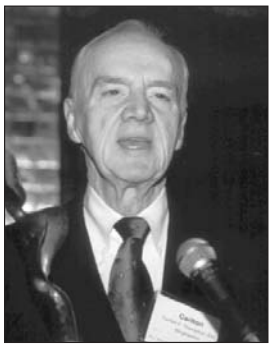
BY MIRIAM H. NETTER

In all, more than a dozen letters from clients, colleagues, opposing counsel and judges were received in support of Carlton F. Thompson, a name partner in the Binghamton law firm of Levene, Gouldin & Thompson, LLP, to receive the New York State Bar Association's Third Annual Attorney Professionalism Award for his exemplary skills and civility in the practice of law.

As one young lawyer put it, "If the question were posed, who best exemplifies the type of lawyer you would like to be when you grow up, I would certainly have to answer, Carlton F. Thompson."

The award, given by the NYSBA's Committee on Attorney Professionalism, was presented by President-elect Lorraine Power Tharp of Albany to Thompson during the Association's 125th annual meeting.

Thompson, a *magna cum laude* graduate of Syracuse University, earned his law degree from Syracuse University College of Law (Phi Beta Kappa, Phi Delta Phi and Justinian Society).



"Carl has combined the highest standards of professionalism with a very successful career in medical malpractice litigation. His consideration of others, his mentoring of young lawyers and his unfailing courtesy and civility in what could be a contentious practice area, have earned him this recognition," said John Stuart Smith of Rochester (Nixon Peabody, LLP), the committee chair.

Highly regarded as one of the foremost defense lawyers in upstate New York, he used his strong organizational skills to develop protocols for providing an effective defense in medical liability matters, a model for attorneys practicing in this area of the law. Thompson is a Fellow of the American College of Trial Lawyers, a past chair of the NYSBA's Trial Lawyers Section and a past president of the Broome County Bar Association. He has lectured extensively to hospital staffs and medical societies concerning risk management and malpractice defense strategies, and is known for assisting his colleagues in these areas.

The Attorney Professionalism Award was established to recognize attorneys who have demonstrated the highest standards of professionalism, including dedication to service of clients and commitment to promoting respect for the legal system in pursuit of justice and the public good, characterized by exemplary ethical conduct, competence, good judgment, integrity and civility.

Previous recipients include Barry Kamins of Brooklyn (Flamhaft Levy Kamins & Hirsch) and Lucille A. Fontana of White Plains (Clark, Gagliardi & Miller).

David M. Gouldin, a partner and 50-year friend who nominated Thompson for the award, said, "I knew him when he was a young lawyer in my father's firm and I was just about 10 years old. He became my mentor when I first started practicing law more than 35 years ago. The richness of what he has to offer others as a true gentleman and as a lawyer, and how graciously and willingly he has done so, never ceases to amaze me."

Nomination forms for the 2003 Attorney Professionalism Award may be obtained by contacting Terry Brooks at the Bar Center (518) 463-3200 or tbrooks@nysba.org. Nominations must be submitted no later than October 8, 2002.

MIRIAM M. NETTER is a member of the Committee on Attorney Professionalism and chairs the subcommittee that administers the Attorney Professionalism Award.

Testimonials

Following are excerpts from some of the letters that recommended Carlton F. Thompson as the 2002 recipient of the Attorney Professionalism Award.

"Despite his stature as the highly respected and regarded senior partner of a leading upstate firm, Carl has always had a gentle, unassuming personality and a sense of openness and respect for everyone with whom he comes in contact. In the courtroom and in the community he is unfailingly fair minded, courteous and respectful."

Justice Robert S. Rose of Binghamton, Supreme Court, Appellate Division, Third Department.

"He never raised his voice in anger, even under the most stressful of situations. On the contrary, he frequently acted as mediator when matters became hot. In his calm and quiet manner, he often negotiated a compromise when an offending question was posed at a deposition, always cautious not to embarrass or belittle opposing counsel."

Catherine A. Gale of Fayetteville, Gale & Dancks, LLC.

"His integrity, honesty, and straight forward, above reproach demeanor have earned him the respect of friends and peers—Carl has been a mentor to me in the truest sense of the word."

Leonard Feld, MPA, former corporate director of risk management.

Language Tips

By Gertrude Block

Question: Attorney Eric Napoli, who lives in Spain, writes that a friend who takes English classes from a European teacher asked the teacher whether the phrase, "to make a decision" or "to take a decision" was correct. The teacher explained that either was correct, but "take a decision" was preferable. Attorney Napoli wrote that he told his friend that he thought the teacher was wrong because idiomatic English requires "make a decision." Attorney Napoli added that because in Spanish decisions are "taken" (*tomar una decision*), and he has become so accustomed to Spanish usage, he wonders if he gave his friend the wrong advice.

Answer: His advice was correct. Idioms vary from language to language, and they have no grammatically logical basis. The 1993 edition of the *Columbia Guide to Standard English* states that "if a locution is idiomatic, it is standard because we have all agreed it is logical." So Spanish speakers agree to "take decisions," while English speakers agree to "make decisions."

From The Mailbag:

Several readers have responded to the question that appeared in the March/April *Journal* about whether *enclosure* or *attachment* is the better choice when fastening documents to e-mails. Attorney Maitland Kalton, who practiced for 19 years in England but has recently moved to New York, prefers "I attach," or better yet, "attached is." On the other hand, Attorney Heidi Keschenat points out that e-mail, merely a faster method of communication, should retain the formality of a normal letter. She therefore uses *enclosure* for documents attached to e-mails.

Thanks to both readers and others who responded, the slight majority of whom preferred *attached* to *enclosed*.

Potpourri:

Attorney William H. Hagendorn, of the New York firm of Burlingham Underwood LLP, (an old-time admiralty firm, which represented the owners of the *Titanic*) sent me a wonderful item, which he called, "Demise of the female (gender) form." On March 20, 2002, *Lloyd's List*, a distinguished British insurance and shipping newspaper founded in 1734 and read by many U.S. admiralty and maritime lawyers, decided that, beginning on April 1, ships would be referred to in the neuter gender, thus abandoning the historic tradition of referring to them as female.

Readers' response to the *Lloyd's List* article was immediate and amazing. As the newspaper noted in its March 22 edition, "the unprecedented response from newspapers and mariners all over the world . . . visibly demonstrated the emotions . . . attached to ships past and present." Headlines of newspaper articles included the following: "Move to take the sex out of ships sparks a mutiny," and "*Lloyd's List* sinks the tradition of calling ships 'she.'"

But even more amazing to this nonsailor was the generally horrified reaction of *Lloyd's List* readers, some of whose letters were printed in the March 22 edition of the newspaper. One reader wrote: "Seafarers are dying while you attempt to score cheap circulation points over your principal rival." Another reader wrote: "Only a bunch of crusty, out of touch, stuck up Englishmen would dream of trying to change the way we've spoken of ships for 1000s of years as 'she.' Get out of there and go tend to your gardens and hunt foxes, you arrogant ass holes."

A third imagined how his dead brother would feel: "My brother spent many years with *Lloyd's Register*. He would certainly turn in his grave if this happens. Whatever bureaucrat considered such a step obviously should have never had anything to do with ships in the first place." And another correspondent labeled the announced change "over-zealous political correctness," and added, "A ship may be a commodity to you, but to the men and women who put to sea and whose lives depend upon them, they are more. Where is your sense of fun and your sense of tradition? Our culture dies the death of a thousand cuts."

Only two writers approved of the change. A woman reader wrote, "I just wanted to thank the editor who was wise enough to realize that referring to ships as 'she' is both archaic and insulting to women. . . . The editor who had the guts to . . . take a stand on this should be commended and receive a huge salary increase."

Finally, a reader expressed my feelings when he wrote, "Why there should be such antipathy to your proposals is a mystery. I undertook a poll from the office to test the reaction. To my surprise, I was met with vehement opposition to the idea, but no one could explain why a ship should have gender." Perhaps, he added, the original purpose for making ships female was the feeling of security: "Mariners, faced with unpredictable seas, sought comfort from ascribing a maternal aspect to their vessels."

The enraged emotions that the name change aroused is indeed inexplicable to most of us. It brings to mind, however, the strong feelings that the word *hopefully* brought forth in some Americans when it first became common. Traditionally, *hopefully* described the feeling of the individual: "He hopefully baited his hook, though the fish were not biting." More recently, however, it became a sentence modifier: "Hopefully the weather will be nice for the wedding."

Most people accepted, or were perhaps unaware, of this meaning change, but for a few readers it was sacrilege. It was reported that one such person placed a sign over her front door that read, "Abandon *hopefully* all ye who enter here."

My thanks to Attorney Hagendorn for sending this material, which indeed reveals how emotional people can be about language.

Gertrude Block is the writing specialist and a lecturer emeritus at Holland Law Center, University of Florida, Gainesville, FL 32611. Her e-mail address is Block@law.ufl.edu.

Editor's Mailbox

Attorney Regulation and Discipline

I write in response to Steven C. Krane's parting *President's Message* which appeared in the May 2002 issue of the *Journal*.

While most would agree improving the justice system and access to it, as well as protecting the interests of New York attorneys are laudable goals, I respectfully disagree that those interests can be advanced while attorneys continue to be admitted and regulated solely at the state level.

Although Mr. Krane asserts that "we must avoid becoming a protectionist guild," our profession's provincial thinking has prevented us from keeping up with the changing needs of the legal system and society as a whole.

If the justification for this parochial view is attorney regulation and discipline, note that few states have strayed very far from the Code of Professional Responsibility or the Model Rules of Professional Conduct. An attorney can usually arrive at an answer to an ethical situation no matter which set of rules is applied. Then too, no state would likely refuse a national system of bar admission simply because the state judiciary and bar would prefer its attorneys to be less ethical than the prevailing national standard.

As for bar examinations, the exams themselves are gradually nationalizing anyway; 49 out of 50 states have adopted the Multistate Bar Examination for at least part of a candidate's final score, and numerous states have now adopted the MPT starting with the February 2002 examination.

Additionally, despite attorney resistance, our society, being increasingly global, is increasingly national as well. Our provincial restraints on multi-jurisdictional admission and practice run afoul of the general trend, and we have failed to become as mobile and global as our own clients, whether they are multinational corporations or impoverished criminal defendants. Improving the justice system and increasing universal access can both be accomplished once clients may choose their counsel without interference from our archaic guild mind set.

When other professions nationalized their standards, practitioners and clients benefitted from the increased mobility, while we continue to suffer under the weight of the powdered-wig jurisprudence of previous eras.

Yet, despite the nationalization, can anyone say that those professions were irreparably damaged by the broader approach? The American public still holds physicians, accountants, and engineers in higher esteem than lawyers, and yet we maintain, without justification, the national professional testing and licensing will somehow tarnish our profession and image. Those other professionals, unencumbered by such restraints, have been able to serve their clients no matter where they are located, and yet they are no less subject to professional discipline or civil liability. The continuing adherence to professional ethics can be maintained simply because the consequences of misconduct would be national rather than local in nature.

Wesley M. Brown
Hamburg, N.Y.

New Members Welcomed

FIRST DISTRICT
Vardit Afriat
Harvey Agosto
Ryutaro Aida
Payam Akhavan
Ahmad Ammar Al-sati
Edward George Angelini
Rita F. Aronov
Deborah Lynn Axt
Ilonka Aylward
Jessica Lynn Bagner
Elena Baier
Melissa Jill Baily
Jonathan Scott Ball
Leslie Macdonald Ballantyne
Jennifer Tara Barall
Harsha Barot
Santo Barravecchio
Maria Helena Barrera Balarezo
Alexander David Barry
Serra Ayse Basoglu
Ryan Robert Bekkerus
Jennifer L. Beller
Orit Benitah
Gian Paolo Berard
Ross Michael Bernard
Benjamin Keith Bernstein
Paul P. Bertoni
Kenneth Tod Bierman
Stefanie Jill Birbrower
Maurice Blanco
Barry James Bleichner
Matthew J. Blit
Stacy Leigh Bogert
Alessandra M.Z. Boin
Charles Joseph Boudreau
Maria A. Bove
Joshua Eric Bowers
Philip M. Bowman
Walter H. Boxer
Cecile Boyer
Yekaterina Boyko
David A. Brauner
Andrew Hardin Bray
Christopher Scott Brennan
Hannah Breshin
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Jay Daniel Brody
Katina Brountzas
Jennifer P. Brown
Justin M. Brown
Matthew A. Bryskin
Kim Tomsen Budinger
Holly April Bunnell
Ram Burshtine
Amber Therese Busuttil
Coriander Joy Cahn
Arlety Campos
Thomas James Cannon
Jason H. Carls
John Luke Castelly
Scott Anthony Catlett
Shawn Michael Cestano
Gale Kuei-ling Chang
Jacqueline C. Charlesworth
Roland Sydney Chase
Hewson Chen
Shana W. Chen
Yixin Chen
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Juliette Y.C. Chinaud
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Abesh Choudhury
Leontine Denise Chuang
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Kangja Chung
Erin M. Coffer
Robert S. Cohen
Rachel Coleman
Kristin Ann Collins
Kristine Werkmeister Collins
Maro Artemis Constantinou
Tara Pam Cook-Littman
Michael B. Coons
Douglas Santino Corleone
Cristina Coronado
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Brian Walter Crist
Theresa Crotty
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Adam Seth Hootnick
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Michelle M. Hyland
Shima Imoto
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Deidre Jackson
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Anthony Michael Bellini
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tress. But—go figure. The rhetoric will not be verbiage.

1. *Olmstead v. United States*, 277 U.S. 438, 485 (1928) (Brandeis, J., dissenting).
2. *First Iowa Hydro-Elec. Coop. v. Federal Power Comm'n*, 328 U.S. 152, 187 (1946) (Frankfurter, J., dissenting).
3. Vernon Countryman, *quoted in* Bruce Nash et al., Lawyer's Wit and Wisdom 50 (1995).
4. King Louis XII of France, *quoted in* Bruce Nash et al., Lawyer's Wit and Wisdom 46 (1995).
5. Daniel J. Kornstein, *Surviving Your First Year in the Law: Improve Your Writing, Gain a Potent Weapon*, N.Y.L.J., Sept. 5, 2000, at S.9, col. 1 (emphasis added).
6. The following four examples, and the allegory, appear in Michael R. Smith, *Advanced Legal Writing: Theories and Strategies in Persuasive Writing* 183–84, 201 (2002).
7. *Smith v. Allwright*, 321 U.S. 649, 669 (1944) (Roberts, J., dissenting).
8. *Edwards v. California*, 314 U.S. 160, 186 (1941) (Jackson, J., concurring).
9. *Conroy v. Aniskoff*, 507 U.S. 511, 519 (1993) (Scalia, J., concurring) (citation omitted).
10. *Buckley v. Valeo*, 424 U.S. 1, 19 n.18 (1976) (per curiam).
11. *Coyle v. State*, 693 S.W.2d 743, 745 (Tex. Ct. App. 1985) (Sparling, J., concurring).

GERALD LEBOVITS is a judge of the New York City Civil Court, Housing Part, currently assigned to Brooklyn and Staten Island. An adjunct professor and the Moot Court faculty advisor at New York Law School, he has written numerous articles and *Advanced Judicial Opinion Writing*, a handbook for New York State's trial and appellate courts, from which this column is adapted. His e-mail address is Gerald.Lebovits@law.com.

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THE LEGAL WRITER

Not Mere Rhetoric: Metaphors and Similes—Part II

BY GERALD LEBOVITS

Learning about metaphors like those in last month's Legal Writer column is like recalling a high-school literature lesson: A wolf in sheep's clothing at first, it can turn into the apple of your eye. More dead, proverbial, clichéd metaphors appear in the law than you can shake a stick at. But rhetorical advice the masters offer aplenty. Study, for example, Justice Louis Brandeis's guidance: "Our Government is the potent, the omnipresent teacher."[1]

Similes

If apt, concrete metaphors are gifts for those you want to persuade, similes are like presents that will make your readers smile. A simile is an explicit comparison, comparing dissimilar things, using *like*, *as*, *as if*, or *as though*. Similes are distracting when repetitious but powerful when image provoking.

Justice Frankfurter on lawyers' exaggeration: "After all, advocates, including advocates for States, are like managers of pugilistic and election contestants, in that they have a propensity for claiming everything."[2]

Belly up to the bar: "The bar is still dominated by shortsightedness and self-interest. Spotting change there is like watching a glacier move."[3]

If the shoe fits: "Lawyers use the law as shoemakers use leather: rubbing it, pressing it, and stretching it with their teeth, all to the end of making it fit for their purposes."[4]

Good legal-writing advice: "Don't write *like* a lawyer. Write *as* a person unspoiled by the law."[5]

To use similes correctly, you must know the difference between *as* and *like*.

As is a conjunction when followed by a verb: *Correct:* "*As* Rome burned, Nero fiddled." *Correct:* "She felt *as if* [or *as though*] she made law review." *As* is a preposition when followed by a comparison and no verb. *Correct:* "*As* [not *like*] a New York State court attorney, I follow the *Tanbook*, not the *Bluebook*."

Like is a preposition that governs nouns and noun phrases. *Like* is not a conjunction. *Correct:* "Like his father, Samuel Hand, and his grandfather, Augustus C. Hand, Learned Hand was a famous judge." *Incorrect:* "Like I said, don't use no double negatives." *Should be* "As I said . . . ."

Combining Metaphors and Similes

Great legal writers combine metaphors with similes in a single sentence. See whether you can figure out which is the metaphor and which is the simile.[6]

Justice Roberts: "The reason for my concern is that the instant decision, overruling that announced about nine years ago, tends to bring adjudications of this tribunal into the same class as a restricted railroad ticket, good for this day and train only."[7]

Justice Jackson: "Unless this Court is willing to say that citizenship of the United States means at least this much to the citizen, then our heritage of constitutional privileges and immunities is only a promise to the ear to be broken to the hope, a teasing illusion like a munificent bequest in a pauper's will."[8]

Justice Scalia:

> [T]he use of legislative history [is] the equivalent of entering a crowded cocktail party and looking over the heads of the guests for one's friends. . . . [T]he legislative history of § 205 of the Soldiers' and Sailors' Civil Relief Act contains a variety of diverse personages, a selected few of whom—its "friends"—the Court has introduced to us in support of its result. But there are many other faces in the crowd, most of which, I think, are set against today's result.[9]

The Supreme Court *per curiam*: "Being free to engage in unlimited political expression subject to a ceiling on expenditures is like being free to drive an automobile as far and as often as one desires on a single tank of gasoline."[10]

Required are time and practice to illustrate with clever, memorable metaphors and similes.

Putting your finger on figures of speech is like adding shape and body to your legal writing.

Allegories

An allegory, or symbolic story, resembles an extended metaphor. Allegories are rare in legal writing, but here is one:

> I liken the area of law to the allegory of the woodcutter who attempted to cut firewood in uniform lengths. Instead of measuring each successive log to the original, he measured it to the log cut immediately before. At the end of the cord, he discovered that the last log bore no resemblance in length to the first.[11]

Want your legal writing to look like a class act? Illuminate with metaphors and similes. It will be as if your writing took on a touch of class. Required are time and practice to illustrate with clever, memorable metaphors and similes. The law, after all, is a jealous mis-

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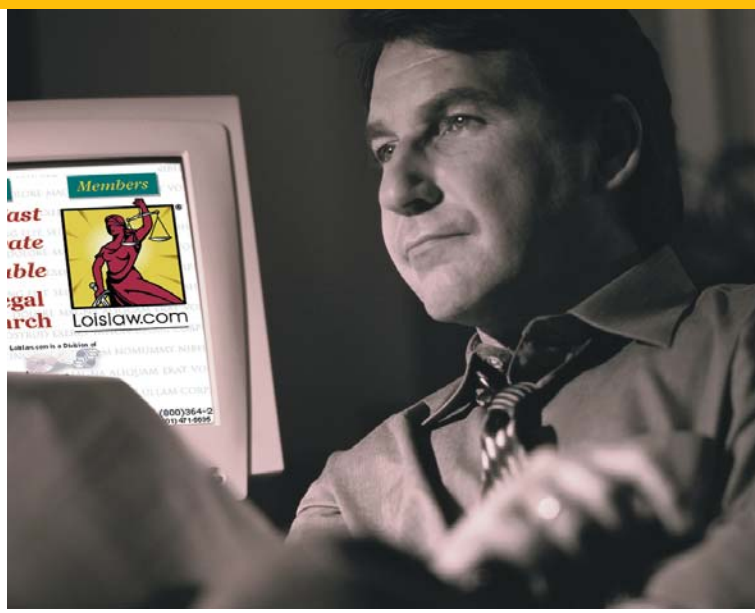

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