AHRMNY
The Association for Healthcare Risk Management of New York, Inc.

The Risk Management Quarterly

FALL 2011

In This Issue

PRESIDENT'S MESSAGE

Dear Members:

Greetings AHRMNY members. A number of us were in Phoenix last month for the Annual ASHRM conference. The weather was warm and sunny and the presentations were interesting, timely and informative. Our New York contingent had fun and there was a well attended reception for our New York attendees at the Sheraton in Phoenix.

In New York we started off the academic year with our inaugural webinar on Section 111 Reporting by Michael R. Merlino II, Esq. of Sedgwick CMS. This webinar went smooth and was well attended. We plan on doing many more webinars in the future. It is a great way to reach members and attendees who cannot appear at our live events in person.

Our Education Committee has been working diligently over the last few months to plan conferences for this year. We ask that you save the date for December 8, 2011 for a half day conference at Lenox Hill Hospital regarding Innovations in the Handling of Medical Malpractice Cases in New York State Civil Courts with featured speaker Judge Douglas E. McKeon, a Civil Court Judge in Supreme Court, Bronx County and also Daniel J. Vukelich, President of the Association of Medical Device Reprocessors who will speak on the history and recent developments in the reprocessing of single use devices. We anticipate a very large turnout for this event.

In addition, The Publications Committee has been diligently working on articles and preparing this Risk Management Quarterly. We are sure you will find it as informative and engaging as ever.

Our Membership Committee reports that 283 members have joined or renewed their membership for the 2010-2011 year. If you haven't renewed yet please do so as soon as possible.

There is also still time to join any committee that you are interested in. The Committee commitment is usually a once a month conference call with some follow up planning and implementation of assignments. Please consider joining. Your participation is needed and appreciated.

Looking forward to seeing you in December.

Jon

EDITOR'S CORNER

The Risk Management Quarterly (RMQ), the official journal of the Association for Healthcare Risk Management of New York, Inc. is published four times a year.

RMQ's Mission Statement: To enhance the quality of healthcare delivery through education, research, professional practice, and analysis specific to risk management issues.

This journal contains articles on a wide variety of subjects related to risk management, patient safety, insurance, quality improvement, medicine, healthcare law, government regulations, as well as other relevant information of interest to risk managers. The articles are usually written by ***AHRMNY*** members, so the journal serves as an opportunity for members to showcase their writing talents.

For the official ***RMQ*** Author Guidelines visit our website http://www.ahrmny.com

Reminder:

Maximum article length 3,500 words

Photo requirements: (high resolution JPEGs – at least 300 dpi)

AHRMNY will not publish those articles promoting products or services

The information presented in ***THE RISK MANAGEMENT QUARTERLY*** is for educational purposes only

WE WANT TO HEAR FROM YOU FOR THE WINTER AND SPRING EDITIONS

We are asking our readers to submit articles to appear in the winter and spring editions of ***The Risk Management Quarterly***. Submission of articles that focus on safe patient care practices, safe working environments, legal and financial updates in the health care arena are some of the topics we seek.

RMQ is published four times a year with a distribution of 200-300 copies per quarter. Please forward any ideas or submissions for publication in the ***RMQ*** to "**Editors"**, via email with attachments to: ahrm@optimum.net

The deadline for submission and consideration for the next journal is **January 19, 2012**.

AHRMNY PRESENTS ITS:

FALL HALF-DAY CONFERENCE
Thursday, December 8, 2011
LENOX HILL HOSPITAL

NYS Medical Indemnity Fund and the
Early Resolution of Claims
Hon. Judge E. McKeon, Twelfth Judicial District
Bronx County Supreme Court

Reprocessing of Single Use Devices
Daniel Vukelich, President & CEO
Association of Medical Device Reprocessors

Funding for this program is provided by our generous sponsors:

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SAVE THE DATE FOR THESE UPCOMING EVENTS

February 3, 2012
Venue: Webinar
Topic: Hurricane Management

March 27, 2012
Evening Educational & Networking Session
Venue: Lighthouse International
Topic: Mock Jury Trial

June 8, 2012
Annual Full-Day Conference
Venue: Lighthouse International
Topics to be determined

CULTURE TRANSFORMATION IN PATIENT SAFETY

How the Just Culture movement can help drive accountability and a safer system of care

By Kathy Martin and Patricia Daughenbaugh

Over a decade ago, the Institute of Medicine (IOM) issued its clarion call to healthcare providers to decrease the number of medical errors.[1] While progress has been made, the Consumers Union Safe Patient Project recently noted that "10 years later, a million lives have been lost and billions of dollars wasted" because "efforts to reduce the harm caused by our medical care system are few and fragmented."[2]

There have been significant successes such as the increased use of prophylactic antibiotics prior to surgery.[3] Also noteworthy, providers are moving beyond the single lens of quantitative analysis and beginning to apply qualitative methodologies to identify contributing factors to medical errors. Yet large-scale improvements remain elusive. For example, avoidable patient safety events such as postoperative sepsis rates[4] and decubitus ulcers[4] are on the rise. At times, the goal of creating a healthcare system free of preventable medical harm seems as far away now as it did 10 years ago. However, one approach does suggest cause for optimism. Many healthcare organizations are finding that implementing a Just Culture can be a true game-changer, enabling a meaningful reduction in medical errors through greater staff accountability and systematic safety improvements.

Overcoming long-standing barriers

Progress in reducing preventable medical errors has been slowed by three factors that are common to most U.S. healthcare institutions:

- Lack of effective data collection and analytical tools to pinpoint breakdowns in the patient care process
- An aggressive legal environment in which the fear of retribution makes clinicians hesitant to publicly share data on medical errors and near misses
- An institutionalized culture of silence in which trust between clinical stakeholders is low and the fear of negative professional and disciplinary repercussions overrides the desire to disclose problems

Progress on the first two issues has been encouraging in recent years. A revolution in patient safety and event reporting is under way, and it's overcoming the technological and legal obstacles that have made gathering error data so difficult. First is the advent of sophisticated event reporting systems that give caregivers the means to quickly and easily record data on adverse events, no-harm events, and near misses. Unlike the rudimentary and laborious methods of old—including paper and pencil, Excel® spreadsheets, and cumbersome bolt-on HIS modules—these advanced systems capture the contextual information about events and have an underlying taxonomy that enables aggregation and analysis of events to derive meaningful insights. Despite these advantages, however, the majority of healthcare organizations have yet to embrace the advanced event-reporting technologies. The second issue—the fear of legal retribution for disclosure of adverse and near-miss events—has been significantly defused by the passage of the Patient Safety and Quality Improvement Act in 2005 and subsequent federal regulation that removed the risk of liability associated with reporting event data. As of January 2009, hospitals can report event data to a Patient Safety Organization (PSO). The PSO de-identifies the data so it cannot be traced back to individual hospitals or patients and sends it to the National Patient Safety Database. This "safe harbor" environment encourages the sharing of data on adverse events and near-misses across providers, regions, and specialties, creating a rich information source to help institutions uncover and correct the systemic factors that undermine patient safety. As of September 2010, there were 87 PSOs operating across the United States, according to the Agency for Healthcare Research and Quality.

Proactive risk reduction

One example of event reporting technology is the Medical Event Reporting System (MERS), developed by the International Center for Health Outcomes and Innovation Research, supported by a grant from the Agency for Healthcare Research and Quality (AHRQ). Early adopters of the Web-based system are enthusiastic. "Our goal is to move from simply reporting adverse events to proactively addressing them," says Claudia Colgan, Vice President of Quality Initiatives for the 1,100-bed Mount Sinai Hospital in New York City. "MERS is an invaluable tool for risk reduction and systematic quality improvement."

Replacing the culture of silence

Far less progress has been made on the third hurdle—overcoming the "institutional hesitancy" within most healthcare organizations to report errors. This, in fact, may be the biggest barrier of all. It should be noted, first, that healthcare workers are devoted professionals who operate in complex systems to treat patients with challenging conditions. The magnitude of errors in our healthcare system cannot be explained away or resolved by collectively pointing fingers at individuals. The complexity of healthcare today generates billions of opportunities for human error, and protecting patient safety requires an understanding of the many ways these errors— usually honest mistakes made by honorable people—can occur.

Traditionally, it has not been culturally acceptable for medical professionals to report on the errors of their peers, much less admit their own shortcomings. This is due mainly to the punitive ways in which error is managed in hospitals and other healthcare organizations. Dr. Lucian Leape, a leader in the patient safety movement, says the single greatest impediment to error prevention is that "we punish people for making mistakes."

Punishing individuals fails as an error management model because the organization as a whole is not given the opportunity to learn from the errors that have occurred. The opportunity to uncover systemic problems in existing care delivery processes is squandered. The conditions that led to the error remain unidentified and unexamined, lying in wait to cause harm to another patient. An unintended consequence of this error management model is that clinicians are less inclined to report adverse or near-miss events for fear of reprisal.

This is not to say that negligent or reckless conduct should be tolerated or go unpunished. The problem is that unintentional mistakes—many of which arise from inherently unsafe institutional processes and practices—are lumped into the same category with egregious violations from a disciplinary standpoint. This creates conditions that encourage clinicians to stay silent, rather than report events that could lead to operational changes that save lives.

What is an error?

Creating a learning culture that adopts error reporting requires organizational consensus about what constitutes a medical error. Without clear definitions, staff will not be able to recognize and report events accurately. One framework suggested by patient safety experts delineates four categories of problematic behaviors:

Human Error—inadvertent lapses or mistakes

Negligence—failing to exercise the skills expected of a healthcare provider

Reckless Conduct—consciously disregarding a visible, significant risk

Intentional Rule Violation—choosing to deliberately violate a rule when performing a task

An organization that learns from its errors

The Just Culture movement is about creating a work environment in which healthcare professionals are motivated to recognize, report, and reform unsafe care practices. This requires developing organizational consensus about what constitutes a medical error and replacing an overly punitive approach to error management with a system of positive reinforcement for safe behaviors.

Safety consultant David Marx, JD, a pioneer in the movement, stresses the need to find a middle ground between a blame free culture, which attributes all errors to system failure and says no individual is held accountable, and an overly punitive culture, where individuals are blamed for all mistakes. The core of Just Culture is the belief that the system can learn from the error and make improvements that enable safer delivery of care throughout the institution.

Interestingly, other high-risk professions such as the aviation industry have seen significant reductions in adverse events by deliberately creating a work environment in which those who bear the greatest responsibility for ensuring customer safety (the pilots) feel empowered and protected in coming forward to report errors and near misses.

Achieving this level of cultural acceptance within healthcare requires long-term planning and cross-functional teamwork. There are five basic tenets to creating a Just Culture that encourages accountability and open communication about errors in healthcare:

1. **Create a proactive learning culture**

   Rather than viewing adverse events and near-misses as something to be fixed, healthcare personnel in a Just Culture see them as opportunities to understand risk within the organization. Using data error reporting to analyze the systemic and behavioral factors at work in a given situation enables management to make better decisions about where and how to apply resources to minimize risk. Managers from Risk/Quality and Human Resources, in particular, have key roles to play in protecting the learning culture and providing processes and tools that promote greater understanding.

2. **Set clear guidelines**

   If caregivers are unwilling to report accurately on errors they witness or cause, the power of other advances in patient safety, like event reporting technology and PSOs, becomes muted. Encouraging accountability requires converting the mindset of staff to being fully engaged in efforts to reduce medical errors, rather than keeping their heads down and not making waves. Clear guidelines must be established and communicated to physicians and nurses that define what constitutes a reportable error, and how and when such events should be reported.

3. **Respond to the data**

   Staff members need to see the data they report is being acted upon. If they sense this information is going into an administrative "black hole" or languishing in an online repository, they will stop reporting. It's critical to establish a response protocol that identifies the staff members on the response team, determines who will examine the event data, and lays out the follow-up steps. Having stakeholders from different levels and disciplines within the organization on this response team is essential. A multi-disciplinary group will view and analyze the data through unique clinical and administrative filters, which can provide a critical "check and balance" function in determining the appropriate system changes required.

4. Design a safer 'highly reliable' system

Using the knowledge gained about what errors are occurring and the systemic vulnerabilities that contribute to them, you can begin to design a safer care delivery system. Although no approach is perfect, care protocols based on real-world intelligence about safety hazards can help prevent failures from occurring, enable earlier identification of failures before they result in patient harm, and provide redundancy to limit the effects of failures that do occur.

5. Measure for continuous improvement

You can only manage what you measure. Having line of sight to the baseline safety performance of care delivery processes provides the benchmark for setting goals, measuring progress and identifying continuing gaps. Let's say, for example, that analysis of event data on in-patients who suffered falls in the hospital in the last quarter revealed that 50% were not preidentified as fall risks at admission. Armed with this information, you not only can re-examine and adjust intake protocols, but also set realistic goals for improvement—say, achieving a 70% identification rate within 12 months—and assess progress at frequent intervals.

What does a Just Culture look like?

Creating a Just Culture is an evolutionary process that typically follows four stages as staff members' understanding and acceptance of the event reporting process increases over time. Key to progression from one stage to the next is the effective application of a response protocol. As staff members experience tangible results from reporting in a non-punitive environment, three things happen: trust builds, reporting improves, and patient risk decreases.

Stage 1. Personnel will typically get their feet wet by reporting on the performance of medical devices or third-party vendors—situations in which the caregiver feels removed from the problem and safe from blame. An example might be that the infusion pump isn't working correctly or the CT scanner has a service issue.

Stage 2. Next, there will be reporting on the actions of other departments. For example, a nurse in the Step-down Unit will enter data on a hospital-acquired infection stating that the patient's central line dressing was not changed as scheduled in the ICU.

Stage 3. A significant cultural shift occurs at this stage, when staff members feel comfortable revealing events that occur within their own departments. An OR manager, for example, will report that a patient's surgery was delayed because Dr. Smith was 45 minutes late for the case.

Stage 4. The final stage of acceptance is reached when personnel begin reporting on themselves to include system errors where blame is unassignable. This signals that a high degree of trust has been created within the organization and staff members believe that the negative information they provide—even about themselves—will be handled discreetly and utilized effectively.

Operationalizing the Just Culture: a snapshot

The Performance Solutions team recently worked with 13 of the 14 hospitals of Rhode Island and the Hospital Association of Rhode Island (HARI) to implement MERS event-reporting technology and operationalize the cultural changes necessary to create an open, learning environment around medical error reporting. This involved, for example, getting all of the hospitals to abandon their home-grown reporting protocols in favor of a unified platform with standardized error definitions and classifications. The initiative is still under way, but early results have exceeded expectations, says Jean Marie Rocha, vice president of clinical affairs for HARI. "The time saved and efficiency gained through standardization of event reporting is immeasurable. Establishing a common platform was a quick win for our team, giving us richer data to guide our efforts to create a statewide culture of safety," she says.

The power of a raised hand

If there is any hope of solving the complex safety challenges that continue to put patients at risk, it's critical to address the issue from multiple angles. Establishing a Just Culture that moves from blaming individual caregivers in favor of shared accountability and systematic improvement is a good starting point for meaningful change. If more people on the front lines of healthcare feel empowered to raise their hands when things go wrong, we can make real strides in building a healthcare system that ensures fewer things will go wrong.

--- For more information visit nextlevel.gehealthcare.com

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Kathy Martin, Managing Director, consults on patient safety issues as part of the GE Healthcare Performance Solutions group. The group helps transform patient safety within a hospital, using technologies such as near-miss event reporting systems. She is leading the formation of the GE Patient Safety Organization (PSO) and has significant experience with international, federal, and state regulatory projects. Kathy can be reached at kathy.p.martin@ge.com.

Patricia Daughenbaugh RN, MSN, MBA, Senior Consulting Manager, leads the Clinical Excellence consulting practice within GE Healthcare Performance Solutions. As a former Chief Nursing Officer, she understands the clinical, fiscal, and operational challenges facing healthcare organizations. With extensive experience in acute healthcare, she leads her teams in sustaining high-occupancy operations while also pinpointing and mitigating the risks of patient harm. Patricia can be reached at Patricia.Daughenbaugh@ge.com

NEW YORK MEDICAL PROFESSIONAL LIABILITY MARKETS SPEAK 2011

By Bonnita (Bonnie) Boone

I have been an insurance broker, underwriter and consultant in the New York marketplace in excess of 30 years for medical professional liability. The evolution of this marketplace has been tremendous.

Over the years, the healthcare providers in New York have consolidated, there have been insurer insolvencies, and integrated health care systems have formed Regional Health Information Organizations (RHIO's), physicians have banded to form ACO's and the landscape keeps changing.

The Medical Professional Liability Risk Transfer Perspective

The days of there being virtually no options for professional liability insurance to a bustling and enterprising market is refreshing. There were times in the past where commercial carriers would not write excess of the primary marketplace (MLIMC, PRI, etc.).

Today New York State has approximately 39 Risk Retention Group's that are registered for Medical Professional liability and there are numerous captives that function in the state. Let's not discuss claims-made coverage and when New York State finally approved it (1986), when just across the river in New Jersey the coverage had been approved since 1976.

In 1986, New York passed a regulation (section 18 of the Medical Malpractice Reform Act) that mandated the provision for excess limits for New York physicians. The regulation was structured so that all filed New York carriers would be required to be a part of a physician pool that would fund the physicians' excess limits. In 1986, the state also required that healthcare providers report certain medical malpractice incidents to NYPORTS in addition to JCAHO sentinel events requirements.

Following the 2003 Desiderio case, the market felt some relief due to the allowance of structured settlements as opposed to future damages being paid in a lump sum and immediately. This was a major factor in infant cases where future damages (pain and suffering) were not structured. The widely recognized benefit of structuring a loss settlement is that it allows a defendant and his/her insurer to retain and invest the balance of the award before installments come due or purchase an annuity at a discounted cost basis.

In 2007 and 2008, Section 111 of the MMSEA was passed that requires hospitals to report any claim that may involve settlements and payment to a Medicare or Medicaid recipient to CMS.

This year we have the New York Medical Indemnity Fund (NYMIF) that will address future medical costs of neurologically impaired newborns. The fund began operations October 1, 2011 and will apply to all lawsuits for which neither a settlement nor a judgment has been entered before April 1, 2011.

The need for NYMIF is not in question. Last year a Zurich benchmarking study analyzing data from 1997 to 2007 puts New York in the highest category for claims frequency (2.95-5.25 per 100 OBE) and loss cost (4,396-5,540 per OBE).

The NYMIF was part of the state's budget which addressed a projected $10 billion deficit. In addition to the NYMIF there will be a, "global cap," on state Medicaid spending.

I wanted to take the pulse of the marketplace after the NYMIF to see what those carriers writing primary and excess professional liability in New York have to say about recent developments in the market. On a national basis, some basic comments about the commercial and professional liability insurance marketplace are as follows:

- The commercial casualty marketplace as a whole still remains soft. Some experts say it is as a result of an abundance of available capital (in excess of $120 billion industry wide).
- Some say it is the continued improvement of claims frequency and stable severity.
- The combined loss ratio of an insurance company has a major impact on a carrier's profitability. A great deal of the coverage written in this country is by the PIAA's (Physician owned carriers). Their estimated combined loss ratio for 2010 was 93%. Results under 100% are profitable. In 2001 the combined loss ratio for these companies was 144.4%.
- New players enter the market and competition is alive and well. The affect of rate and premium adequacy is up for discussion.
- There is no shortage of capacity or coverage terms.
- Continued efforts of tort reform support the soft and competitive marketplace.
- Heightened awareness of patient safety and risk management have added positively to excellent results and the shift in the marketplace.

Some of the markets I interviewed only write excess insurance in New York State. The largest primary carrier for physicians in the state was also interviewed. Here are the carriers and their representatives that were interviewed:

- Andrew Charron-Vice President of Allied World
- Caroline Clouser-Executive Vice President of ACE Medical Risk
- Ed Amsler-Vice President of MLMIC
- Joe Slaton-Vice President of CNA Health Pro
- Kim Morgan-Senior Vice President of Endurance Specialty
- Matt Dolan-President of IronShore Healthcare
- Robert Allen-Senior Vice President of Torus

There is a consensus that everyone welcomes the Medical Indemnity Fund (MIF) and thought it was a move in the right direction. While many carriers felt it was too early to discuss the benefits of the MIF on rates or premiums for hospital excess programs, all welcomed the reform. Many of the commercial markets write excess and hospital system coverage. Some carriers such as IronShore believe risk should be underwritten based on loss history, patient safety and risk management the risk at hand. "The MIF will not make a poor performing risk a good risk."

IronShore and CNA are going to keep an eye on the solvency of the MIF. The first year the MIF will be funded $30 million via the Health Care Reform Act (HCRA). In years two and three, the MIF will be funded $75 million and $100 million, respectively. The regulation is written such that estimated liabilities must not exceed 80% of the MIF's assets. It is also a concern that the enrollment of the fund may be suspended from time to time depending upon the determined outstanding liabilities.

If a claim is denied based on suspension of the fund, the claim must be paid as if the law was never enacted. The point of attachment and where MIF will benefit and affect a risk has to be considered. Carriers like PRI, HIC and MLMIC write primary limits. The average points of attachment (where risk transfer typically occurs) for hospitals in downstate New York is $3 million to $5 million each and every claim.

All of the markets have conducted an enormous amount of research on the MIF. Torus and Allied World have both consulted with defense attorneys to get their take on it. Allied World has committed to underwriting business and determined they would consider credits as a result of the enactment of the MIF (also based on underwriting the risk). ACE USA, like many of the other carriers, pays attention to their competitors and the market but uses their own proprietary rates.

MLMIC, the largest writer of physicians in the state, welcomes MIF but stresses their rates will stay on their own, based on good loss experience, and risk management. However the MIF will not affect the primary layer of $1 million/$3 million. The limits they write are $1.3 million/$3.9 million.

Because of section 18, there may be an additional $1 million/$3 million excess that could be present prior to application of the MIF.

Endurance is a major carrier of teaching institutions and integrated healthcare systems nationally (They write excess and leads excess a self-insured retention but not primary). They also believe the MIF is a step in the right direction. They are looking at the administration of the fund and will proceed with cautious optimism. It is typical that any tort reform needs to be tested before the benefits can affect a premium base.

Torus thinks that larger systems with captives and large SIR programs will need to complete claims reviews in order to determine what the benefits the MIF may mean to their programs. Endurance agrees and said some of their clients have conducted an analysis and see a 50% savings as a result of the MIF. There may be some subjectivities here since the eligibility of the fund is the decision of the fund administrator.

For good risks, the MIF will make a difference says Joe Slaton of CNA.

Matt Dolan, of IronShore, hopes that hospitals will not lose their focus and continue on the road to improved patient safety and risk management efforts.

How does New York compare with the rest of the country for excess professional liability premiums? Is the market soft in New York?

- Allied World thinks there is more rate adequacy in this market and that leads to more desire to write business in New York.
- ACE has written excess business in this market for 10 years but very cautiously with their underwriting standards in place.
- Allied World entertained business in the market for the last three years and like Endurance they understand the risk (point of attachment, etc.).
- CNA knows the marketplace and has business in the area as a part of national risk.
- IronShore continues to review their business in the region and believes following their guidelines and strategy will determine what they write in the industry.

New York is a considered a difficult market to write medical professional liability as the coverage is long tail and the courts system in New York is exceptional slow, somewhat like Cook County in Illinois.

New York has not been exempted from the competitive marketplace. In addition to these markets there are other insurance carriers that entertain business here such as Zurich, PRI, London and Bermuda markets. IronShore believes the competiveness in this market and for that matter the rest of the country has to do with the surplus of capital in the marketplace.

Torus and MLMIC see some movement on loss trends and defense costs. Torus is seeing a higher severity trend within the first $2m of loss, but losses excess of $2m are closer to 4%.CNA and Allied World think that the New York market does support a good rate online meaning the premiums are higher on excess business than in some parts of the country. The point of attachment is also higher than in some parts of the country (Cook County, Illinois, and some parts of Pennsylvania have higher points of attachment).

When asked what risk he thinks are primary and important in this marketplace, Ed Amsler of MLMIC, said professional liability remains the major focus. Torus agrees and thinks those baby (infant) cases that the MIF will contain will continue to be big risk in New York.

Matt Dolan, Joe Slaton, Andrew Charron and Caroline Clouser see the pressures of healthcare reform, Medicaid and Medicare reimbursement cuts, expenses management and regulatory exposures as the biggest risks in the New York market.

Endurance believes the high wage earner demographics of New York will continue to be a large concern when determining risk. In other words, the average income in New York City is far greater than the average income in the rest of the state which results in higher settlements.

In summary the MIF is welcomed by commercial insurers that I interviewed. The majority of the carriers are not willing to say they will provide any rate relief for hospitals' excess program based on this reform yet. It is far too early to determine the impact of the MIF.

Carriers that believe this reform warrants rate reduction commit to underwriting the business in addition to this reform.

All of these markets have given deliberate thought to the MIF and understanding this reform has become part of the underwriting strategies for the area. All of the comments have been relegated to downstate New York.

New York is experiencing the soft market like the rest of the country. However, it is not as extreme as seen in some other areas. Points of attachment for most carriers is excess of $5 million each and every claim on the professional liability coverage. That coupled with premiums that have some positive margins make this an attractive business environment.

Capital surplus, no capacity restrictions, tort reform, claims frequency decreases and severity stabilization are all signs of soft market conditions. Should the MIF be included here as a reason for soft market conditions?

To New York Hospitals that are utilizing the commercial market: don't decrease your budgets just yet; be conservative. Have discussions with your actuary and defense council.

As a Senior Vice President of Alliant Insurance Services Healthcare division in Chicago and New York, Ms. Boone focuses on Medical Professional liability for Long Term Care, Managed Care Organizations, Hospitals/Integrated Delivery Systems, Physicians and University Medical Centers. She has 32 years in the Medical Malpractice Insurance industry, on the broker and underwriting side of the business.

Her Expertise focuses on program design and structure, manuscript policy wording, captive formation, captive reinsurance and rate/premium analysis, for the above areas mentioned.

She was elected in 2008 and 2009 as a "Power Broker for Healthcare" by Risk and Insurance Magazine and honored by Business Insurance as, "A Women to Watch" in 2008. In March 2011 she was awarded the Peggy Cwick Life Time Achievement Award by the CHRMS group.

Bonnie is an accomplished lecturer and author. She recently spoke at the 2011 RIMS conference in Vancouver BC and scheduled to speak at the IMAC conference in the Caymans December of 2011.

Bonnie is a licensed in 40 states and holds a Bachelor of Arts degree in Communications from Xavier University and is currently working on her MBA.

UPDATE ON EDUCATION

AHRMNY Supports Stony Brook University Health Science Department

The Officers and Board of Directors of AHRMNY have formally expressed support of the proposed Masters of Science in Healthcare Quality and Patient Safety within the School of Health Technology and Management of Stony Brook University. As an organization, we believe that a well trained healthcare workforce who has knowledge of patient safety methodology is critical and there is a gap in available curriculum in New York. Graduates of this course of study will be the first of their kind in New York State.

Risky Business

"When Common Sense is Uncommon"

By: Pamela Monastero, MBA

Dear Risk Manager:

This column, which will appear regularly in the AHRMNY Newsletter, is designed to assist both the novice and seasoned risk manager by presenting brief *pearls of wisdom* based on the experiences of our colleagues. This column is based on the contributions of our constituent members, to whom we are grateful for sharing their experiences. We continue to encourage our members to submit their experiences anonymously for inclusion in this column. Please e-mail any suggestions to Pamela.monastero@nychhc.org or mail to AHRMNY utilizing the RISKY BUSINESS form which can be found on our website at AHRMNY.org. The form permits confidentiality.

COMMON SENSE TIPS FOR STAFF:

The recent 'visit' of Hurricane Irene to the East Coast brought with it the reality that hospital and nursing home evacuations are no longer relegated to our brethren in the Gulf Coast States. Several local facilities were evacuated, including mine--Coney Island Hospital. This quarter's column shares collective experiences and lessons learned from the evacuation and also provides insights from various national resources. One thing is certain, pre-emptive evacuations are here to stay and, as the old adage goes, an ounce of prevention is worth a pound of cure.

There are several factors to consider in planning an evacuation and advance preparation definitely makes for a smoother evacuation. The following should be arranged as soon as possible once evacuation is anticipated:

Advance Planning:

- Make certain that your emergency preparedness plan is ready and key players are appropriately educated and engaged. All leadership and supervisory staff should be trained on the Hospital Incident Command System (HICS). Conduct proactive drills regularly throughout the year;
- Coordinate, in advance, with the Office of Emergency Management and the New York State Health Department;
- It is imperative to have one (and only one) incident command leader and an incident command center—all other players should take their cues from the leader in charge of the command center;
- Establish a sensible location for the incident command center. Ensure that the area has the necessary space, equipment, outlets/cables/internet service to accommodate your electronic needs (i.e. wall clocks, televisions with live feeds, sufficient telephones and computers, fax machines, copiers, radio, conference call capability, etc.). The incident command center should be staffed with key players including: the incident command leader, representatives from the departments of medical affairs, nursing, admitting, medical records, transportation, biomedical equipment, patient relations, public relations, security and a designated scribe;
- Establish a 24 hour phone number that can be accessed by patients, families, staff and receiving facilities. This phone number should be operational even after your facility has been evacuated and closed for the disaster. Communication with patients and families in advance of/during the evacuation is essential to avoid chaos, confusion and anxiety. Prepare handouts to let families know what the process is, contact numbers for your facility and the receiving facilities, etc.;
- Issue walkie talkies and matching colored vests/shirts/or jackets and laptops for key staff;
- Designation of local receiving facilities and development of relationships with the Administration, Public Relations and Medical and Nursing Administrators of these. Prepare a list of contact names, phone numbers, fax numbers and distribute to key staff;
- Receiving facilities should designate a 'go to' person. Work with the 'go to' person to establish a mechanism and time frame to transfer patients to each receiving facility to avoid overloading and taxing the resources of the receiving facility. Each receiving facility should determine the point of entry for transferred patients (i.e. via the receiving facility's ER or direct admit). You must also take into account the transportation resources available to you (see below);
- If you are transferring to 'swing units' (i.e. closed units at receiving facilities that are being temporarily opened to accommodate your patients) be prepared to send staff to operate those units—staff may include attendings and hospitalists, residents, nurses, nurses' aides, social workers, discharge planners, dietary, etc. Once there, staff will need to become familiar with any electronic medical records, different biomedical equipment and pharmacy rules as well as any other essential policy/procedure information—getting as much information on this as possible in advance is key. Designate one of your staff members in the 'swing units' to be the 'go to' person assigned to each receiving facility and include that on the contact list for key staff. Determine staff shifts in advance. Arrange for transportation for your staff to/from the receiving facilities—you may need to consider sleeping arrangements for staff. Staff will be anxious regarding the safety of their own families, especially if they live in the area around the evacuated facility. Annual emergency preparedness education must cover this. A well thought out plan regarding staffing of receiving facilities is essential to avoid confusion and frustration;

- Set up record-keeping systems/software (ideally, an electronic admitting/discharging system or a database) to track patients and their ultimate destinations—it is recommended that forms be developed for this and that multiple copies be made for ambulance crews, the receiving facility, the medical records department, patient relations, public relations and the incident command center;
- If your facility is part of a large healthcare system, make arrangements in advance for ambulance support within your system. If not, establish relationships with outside/private ambulance companies. Private ambulances will likely be needed as '911' ambulances (i.e. FDNY, County ambulances, voluntary ambulances, etc.) will be overwhelmed with other calls;
- There may be a lack of consistent terminology from facility to facility. For example, all critical care units are not alike--some facilities may have multiple ICUs, i.e. respiratory, cardiac, surgical, medical, etc.; some facilities may have step down units for telemetry, respiratory care, other specialty units, etc. Thoroughly identify your patients' conditions, needs and the types of beds required before contacting receiving facilities for bed availability. Many of these advance discussions (as well as discussions or 'clinical report' on the day of transfer) should be physician-to-physician and nurse-to-nurse;
- An orderly evacuation of patients requires a thoughtful rationale as to evacuation strategies, i.e. critical care first with ALS ambulances, evacuation on a unit by unit basis, etc. Determine, in advance, the transportation requirements of each patient i.e. advanced life support (ventilator dependant patients, critical care patients, etc.), basic life support, stretcher or wheelchair transport, ambulance vs. ambulette, etc. This strategy should be established during emergency preparedness planning, not on "D" day. It is key that your evacuation strategy take into consideration the transportation resources that will be made available to your facility;
- Make plans with receiving facilities for the 'repatriation' of patients—receiving facilities may want to return your patients quickly and, once the imminent danger has passed, the incident command center must regroup and make arrangements to transfer the patients back to the facility;
- Prepare forms for receiving facilities to complete when repatriating patients back to your facility;
- Make sure all that of your equipment, including stretchers and wheelchairs, are labeled with your hospital's name and ID numbers and are tracked during patient evacuation;
- Determine which areas/lobbies patients will be evacuated from and coordinate in advance with ambulances. Close all other entrances/exits except designated areas for patient families/visitors. Visitors should not be permitted in evacuation areas;
- Designate physician and nursing 'leaders' to take charge of each unit being evacuated at your facility. Prepare and share a master list of names/extensions/cell phones/walkie talkies of: (a) all unit based physician and nursing leaders'; (b) command center staffers; (c) front line staff evacuating the patients;
- Designate a traffic control person in charge of the actual evacuation for front line staff at each building being evacuated. This person is responsible for calling the shots of unit-by-unit evacuation and ambulance traffic control;
- Establish a centralized area/phone number and person responsible for contacting staff to return to work once the crisis is over. Provide this number and the incident command phone number to all staff;
- If you have a psychiatric unit, special transfer arrangements and mode of transportation will be needed;
- If you have an obstetrical and pediatric unit, special transfer arrangements and equipment will be needed;
- Be prepared to have medical records print/copy essential information to accompany the patient (i.e. history & physical, admitting and working diagnoses, current medication, plan, etc.).

The day prior to the evacuation:

- Consider taking digital photos with patient identifiers prior to transfer;
- Discharging, transferring or placing as many patients as possible in advance of the evacuation will serve to reduce your census, thereby reducing the number of transfers/repatriations;
- Cancel all elective procedures;
- Be prepared to send patients with food and be cognizant of special dietary needs;
- Your pharmacy may have to dispense a supply of medication for each evacuated patient;
- Establish a 'drop dead' deadline time for all evacuation of patients to be completed;
- Notify your local EMS or '911' systems as soon as practicable of the date of evacuation so that new patients are not brought to your facility for treatment and admission;
- Notify the NYS Department of Health NYPORTS system of the evacuation;
- Remind staff of the importance of completing occurrence/incident reports for any untoward issues involving the evacuation;
- Designate someone to call receiving facilities to notify them when each patient is en route;
- Reaffirm with receiving facilities their bed availability as this is fluid. Do this again on the day of evacuation. Promised beds are not cast in stone.

The day of evacuation:

- Hospital visitors, family members and the general population should be kept away from the areas where patients are evacuated from;
- Keep lists of any equipment that was transferred with patients;

- Maintain records of patient transfers;
- On the day of evacuation, limit the numbers of entrances and exits, close the emergency room and out-patient departments as soon as possible;
- Once patients are evacuated, do a room-by-room search of the facility to make sure all patients are evacuated. Mark each door checked with a taped "X;"
- There should be several checks and balances built into the process to ensure that the correct patient is being transferred to the correct facility with the correct medical record/ID band/allergy and DNR wrist bands/equipment/medication and food.

Post-evacuation:

- Work with regulatory agencies (Greater New York Hospital Association is also a wonderful source of information) regarding coding and billing for medical records of 'repatriated' patients;
- Be prepared to coordinate with receiving facilities that may be anxious to transfer your patients back to your hospital. The repatriation of patients requires careful consideration including your staffing levels, timing of arrivals to your emergency room (medical ER, psychiatric ER and pediatric ER);
- Critique your evacuation and repatriation plans and note opportunities for improvement. Consult front line staff, local community members and patients/families involved in the evacuation for comments as well.

Other important considerations:

Obviously, all evacuation considerations cannot be contained within one article. Below are some excellent reference resources. Other important considerations that have not been explored in depth here are as follows:

- Environment of care issues such as facility generators, fuel, inventory levels of food, water and supplies,
- Notification to vendors of evacuation and repatriation;
- Securing of the facility;
- Redirection of communication and IT services;
- Recovery after the crisis and analysis of any damage;
- Notification to appropriate regulatory agencies (i.e. NYS Department of Health);
- Consider designating key staff to remain on site during the crisis;
- Telephone follow-up with patients who were discharged prior to the transfer to ensure that their healthcare needs are met and offer any necessary follow up appointments;
- Consider utilizing forms contained in the Hospital Incident Command Systems guidebook.*
- Consider assigning one of your staff at each receiving facility (including those facilities opening swing units that will be operated by your staff). Having one of your own staff assigned to navigate receiving facilities and troubleshoot any speed bumps is highly recommended;
- Be aware of too many 'cooks in the kitchen;' the incident command leader is THE LEADER;
- Remember, you cannot plan for all contingencies. Be adaptable.

On a personal note, the risk management staff at Coney Island Hospital were actively involved in the evacuation process. It was a rich and rewarding experience to participate in the planning and in the actual evacuation. All of our hospital staff worked seamlessly to move patients efficiently, safely and as quickly as possible to their 'temporary homes." We encourage the other facilities evacuated in New York to write in with any comments or suggestions for a follow-up to this column.

Resources:

"Eye of the Storm: Impact of the 2004 Hurricane Season on Florida Hospitals," Florida Hospital Association, www.fha.org
"Florida Hospital Endures Trial by Hurricane Again," 12/1/05, Hospital Access Management
"Hospital Emergency Evacuation Toolkit," Florida Department of Health, May 2011
"Hospital Evacuation Protocol," Draft March 2006, New York Centers for Terrorism Preparedness and Planning
Evacuation and Sheltering Issues, Greater New York Hospital Association, www.GNYHA.org
New York City Office of Emergency Management, www.nyc.gov/html/oem/hazards/storms.shtml
United States Government Accountability Office, GAO-06-443R, Evacuation of Hospitals and Nursing Homes
FEMA Evacuation Plans, www.fema.gov/plan/prepare/evacuation.shtm
"Hospital Assessment and Recovery Guide," AHRQ Publication No. 10-0081, May 2010, www.ahrq.gov
"Hospital Evacuation Decision Guide," AHRQ Publication No. 10-0009, May 2010
"Hospital Incident Command Systems Guidebook"* August 2006, www.emsa.ca.gov/HICS/files/Guidebook_Glossary.pdf

CONTROLLING PERSONS LIABILITY IN THE LONG-TERM CARE SETTING UNDER NEW YORK LAW

By Steven D. Weiner and Mario C. Giannettino

It is a routine practice in long-term care litigation for the plaintiffs' bar to seek information concerning the identities of certain individuals who operate residential health care facilities, largely to investigate the finances of the facility. The statutory authority for such inquiries is found in New York Public Health Law § 2808-a, which mandates that every individual who is a "controlling person" of a residential health care facility shall be liable, jointly and severally, with and to the same extent as the residential health care facility itself for damages, including civil fines and penalties. The statute defines a "controlling person" as "any person who by reason of a direct or indirect ownership interest (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interests, to direct or cause the direction of the management or policies of said facility".

The Legislative History behind the enactment of New York Public Health Law § 2808-a established that the Legislature intended to subject those persons who "controlled" nursing homes, including operators, to personal liability for damages and civil penalties. The foregoing provision should be of substantial concern to the long-term care industry since Public Health Law § 2801-d permits the recovery of attorneys' fees and punitive damages at the Court's discretion. It also permits class actions, the damages for which can become the responsibility of the controlling persons, and far exceed the limits of any available insurance.

However, Public Health Law § 2808-a(2) carves out important exceptions to the rule of liability set forth above. Specifically, the statute exempts from liability any person who serves as an officer, administrator or other employee or as a member of a board of directors or trustees of any facility as a result of such position or his or her official actions in such position. Yet, despite what appears to be a relatively straightforward statutory framework that exempts officers, administrators, board members or trustees from liability, the plaintiffs' bar nonetheless typically attempt to force disclosure of the financial interests of these persons regardless of whether they possess the necessary controlling interest mandated by the Public Health Law. Unfortunately, there is little specific case law in the long-term care setting analyzing the circumstances under which a controlling person of a residential health care facility can be liable for tort damages in the State of New York. The few cases that do exist appear to limit the application of "controlling persons" liability and, therefore, should serve as a particularly valuable resource in heading off Public Health Law § 2808-a claims.

The leading case discussing controlling person liability appears to be Niagara Mohawk Power Corp. v. Salerno, 20 A.D.3d. 142, 797 N.Y.S.2d. 663 (4th Dept 2005), in which a utility company brought a breach of contract action against the president and sole shareholder of two companies, one of which was the receiver for a residential health care facility and the other of which owned the real property on which the facility was located. Plaintiff contended that as president/shareholder, the defendant owned all or a majority of the stock in the nursing home, thus defendant possessed an ownership interest and was a controlling person as defined by Public Health Law § 2808-a. Defendant countered that it was not a controlling person and that, in any event, a controlling person may not be held liable for breach of contract relating to nonpayment of fees for utility services.

The Fourth Department analyzed the legislative history of Public Health Law § 2808-a and rightly concluded that the section was enacted to allow patients access to another responsible party, other than the facility itself, which could be liable for fines and penalties. However, the Court reasoned that Public Health Law § 2808-a did not create a separate cause of action. Instead, the liability of a controlling person could only be triggered on the basis of a violation of a specific standard of care. The first ground for potential liability was under Public Health Law § 2801-d(1), when a residential health care facility deprived any patient of said facility of any right or benefit. The second basis for liability was pursuant to Public Health Law § 2803(6), which provides that a residential health care facility may be liable for penalties "for violations of rules and regulations . . . pertaining to patient care".

Accordingly, the Fourth Department *dismissed* the plaintiff's claims, holding that Section 2808-a of the Public Health Law did not create a new cause of action to recover against the receiver for breach of contract and, more importantly, even if the president/ shareholder was a "controlling person" of the nursing home, he was not liable for the facility's alleged breach of contract arising from nonpayment of fees for utility services. Essentially, the plaintiff's Complaint was dismissed since plaintiff failed to show any deprivation of patient rights.

While the decision is Niagara Mohawk Power Corp. v. Salerno, is insightful, its precedent is somewhat limited by the fact the plaintiff therein was not a "resident" of a long-term care facility and the case was not seeking damages for a deprivation of a specific patient right, but merely sought damages for breach of contract.

The Second Department also had occasion to analyze Public Health Law § 2808-a in Ocean Side Institutional Industries, Inc. v. United Presbyterian Residence, 254 A.D.2d. 337, 678 N.Y.S.2d. 653 (2 Dept 1998). In Ocean Side, a linen services provider brought an action against a nursing home and its president/receiver to recover damages for breach of contract. The Appellate Division, Second Department, held that, absent allegations of bad faith, the nursing home was immune for liability for losses and the president could not be liable for nonpayment of linen

services as a controlling person under the statute. The Court emphasized the fact that the president did not have any ownership interest in the corporation, and dismissed the action entirely on this linen services as a controlling person under the statute. The Court emphasized the fact that the president did not have any ownership interest in the corporation, and dismissed the action entirely on this ground. This is important since it suggests Courts are willing to limit the application of the Public Health Law § 2808-a under the right circumstances. Unfortunately, the Court never reached the question of whether plaintiff alleged any violation of residents' rights, which seemed to be a persuasive factor in the Niagara Mohawk Power Corp. v. Salerno decision discussed above.

Likewise, the matter of Gorton v. Fellner, 88 A.D.2d 742 (3d Dept), involved a claim of wrongful discharge by a former resident of a nursing home against a former member of the nursing home's partnership. In Gorton, the defendant had withdrawn from the nursing home's partnership four years earlier but no certificate of dissolution was filed and the Department of Health records showed the ex-partner as still active. Plaintiff sued both partners, unaware that one of the defendants had withdrawn from the partnership. Plaintiff did not allege that the withdrawing partner committed any wrongful acts, but merely sought to hold him liable because the records reflected his continuance as a partner.

In determining the propriety of the lower Court's dismissal, the Appellate Division, Third Department, held that there was no showing that the withdrawing partner participated in the conduct of the nursing home business in any manner. Thus, despite the general rule that a tort committed by a partnership may be imputed to all the partners jointly and severally, the record failed to show that the withdrawing partner either authorized or had knowledge of the tortious conduct alleged. The Court opined that liability for wrongful acts could not be created by the failure to file a certificate of dissolution of the partnership, nor was the fact that the Department of Health records showed the withdrawing partner as active, conclusive that he was a controlling person. In determining the lack of liability of the withdrawing partner as a controlling person, the Appellate Division emphasized that the withdrawing partner must continue to have an ownership interest or the power to direct the management or policies of the nursing home, but as neither factor was present there was no basis for liability. Accordingly, the Gorton decision is instructive, but the putative "controlling person" was no longer active and had no role in the decision-making of the facility, which somewhat limits the application of the decision as a whole.

A lower Court decision, Sunrest Properties, LLC v. Sunrest Nursing Home, 8 Misc. 3d. 1028(A), 2006 WLK 1993485, rendered in the Supreme Court, Nassau County, also weighed in on the application of controlling persons liability under Public Health Law § 2808-a. Sunrest Properties involved the closing of one nursing home and the transfer of its residents to another facility. The plaintiff was the landlord of the initial nursing home and alleged that that the defendant put the welfare of the residents in jeopardy by abandoning the initial nursing home and moving the residents to the subsequent facility. Defendant conceded that as partner and president, he was a "controlling person" within the meaning of Public Health Law § 2808-a, but argued that only persons affected had standing to bring an action. In this case, however, none of the former residents or their representatives brought suit but, rather, the action was commenced by a mere landlord of the property.

The Nassau Supreme Court held that as a condition precedent to liability, the aggrieved party must still establish a violation of one of the substantive provisions of Article 28 of the Public Health Law. Accordingly, the action was dismissed since the landlord failed to allege which federal or state statute code, rule or regulation creating a right or benefit was violated. This reasoning would appear to place the decision firmly in line with the logic of Niagara Mohawk Power Corp. v. Salerno. Notably, the case was also dismissed for lack of standing in that the landlord did not possess authority to bring an action on behalf of its former residents.

A curious decision was issued by the Fourth Department in Olszewski v. The Waters of Orchard Park, 303 A.D.2d. 995 (4th Dept). The plaintiff commenced a wrongful death action as the administrator of the estate of the decedent, who died while a resident of the defendant nursing home. One of the named defendants was the sole shareholder and president of the corporate defendant that owned and operated the nursing home. In dismissing the action against the sole shareholder and president, the Court held that the plaintiff failed to adequately allege any basis for holding the shareholder/president personally liable for the decedent's death. In reaching its conclusion, the Fourth Department held that a corporate officer is not held liable for the negligence of the corporation merely because of his official relationship to the corporation. Rather, it must be shown that the officer was a participant in the wrongful conduct. However, what potentially undermines the persuasiveness of the Olszewski decision as a whole is that, unfortunately, there was no discussion of the role and impact of Public Health Law Section 2808-a. It is thus unclear if this decision is an aberration or a shift in the Court's view that Public Health Law § 2808-a requires some element of active participation in the alleged wrongful conduct.

An important decision that did not discuss Public Health Law § 2808-a, but, nonetheless discussed "administrator liability" under Public Health Law § 2801-d is the New York, Supreme Court matter of Morisette v. Terence Cardinal Cooke Health Care Center, 8 Misc.3d 506, 797 N.Y.S.2d. 856 (2005). The defendant moved to dismiss the Complaint pre-discovery as to the facility's Medical Director, based on assertions that the Medical Director never saw or treated the decedent while in residence. Indeed, plaintiff's counsel did not contest that the Medical Director was not directly involved in the subject care. Instead, plaintiff's counsel argued that the Medical Director performed "supervisory" duties. Evaluating the Complaint in the light most favorable to plaintiff, the Court held that plaintiff appeared to be alleging that the Medical Director, in his dual role as the center's Administrator, was negligent in failing to assure that the resident's rights enumerated in Public Health Law § 2801-d were implemented and adhered to with respect to the adequacy of the facility's staffing levels and care planning. Accordingly, the Court permitted the claim to proceed

against the Medical Director for the discovery phase. It would appear that the Morisette decision is inconsistent with the very terms of Public Health Law 2808-a, as the statute exempts from liability an Administrator as a result of their official position or actions within that role.

The foregoing cases, save for Morisette, while largely not based upon claims for deprivations of resident rights, primarily seem to limit the application of controlling person liability. Thus, it appears that the judiciary has demonstrated restraint in applying Public Health Law § 2808-a which favors the defense bar's argument as to why demands by plaintiffs seeking controlling person information should not be ordinarily discoverable in a civil tort action.

Yet, plaintiffs' counsel will seek to erode this distinction and allege that the claimed abuse and neglect of nursing home patients are often the result of systematic problems throughout the entire corporation. For example, plaintiffs will argue that a patient developed decubitus ulcers or fell as a result of inadequate staffing, and that the decision not to hire more staff was directed from above. By and large, such arguments appear inconsistent with the very terms of the Public Health Law since the statute exempts from liability officers, administrators or members of the Board of Directors simply because of their positions or official actions in such positions.

The potential impact for the long-term care community is that a Court may issue a rogue decision permitting inquiries into a controlling persons interests and, thus, completely eviscerate the current case law, especially since, in New York, Courts permit discovery of any information that is "material and necessary" under Article 31 of the C.P.L.R. If access to controlling person information became a topic of customary disclosure, the discovery phase of litigation would be expanded to even a wider scope, which creates more challenges for the facilities and their defense counsel. As it presently stands, plaintiffs in long-term litigation typically depose numerous staff members who were actually involved in resident care and request a plethora of documentation from the facility, including personnel records, case mix indices and staffing information. The next step may be to permit plaintiffs more ready access directly to the members of long-term care facilities' administrative and governing bodies to inquire about budgetary information, operating costs, salaries, the process of establishing and approving policies and procedures, and more importantly, profits. Moreover, in today's climate, nursing homes are often viewed unsympathetically. It is not difficult to imagine a plaintiff arguing that controlling persons are in business solely to make a profit, and did so at the expense of the residents of their facilities, most of whom are elderly, vulnerable and fragile.

In summary, at the moment, controlling persons liability under Public Health Law 2808-a appears to favor the position that Courts are restricting the liability of such persons and, correctly, have refused to interpret the statute beyond its plain terms. However, it is critical that given the lack of a single, persuasive judicial authority and the willingness of the plaintiffs' bar to force disclosure of such information, controlling persons should, at a minimum, be sure that the organization maintains proper directors' and officers' liability insurance. With such safeguards in place, as well as retaining defense counsel that is well-versed with the current state of law regarding controlling persons' liability, Public Health Law 2808-a, will be a far more blunted sword than some intend.

The Authors:

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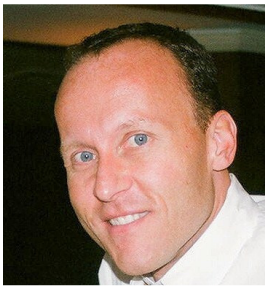
ON NY CHAPTER MEMBERS

Congratulations to Diane Longo who recently earned her Certified Professional in Healthcare Risk Management (CPHRM) designation

* * * * *

Congratulations to Mike Midgley for becoming a Fellow of ASHRM and making the Dean's list at Fordham Law School. Mike will graduate in December 2011 and will be taking the bar exam in February 2012



EMERGING HEALTHCARE TECHNOLOGY

ROBOTIC SURGERY

By Dylan Braverman and Ari Erlichman

As risk managers, there is a level of trust that is placed on the attending surgeons who treat the patients at our facilities. Since in a clinical setting, trust is never blind, it is bolstered by a thorough privileging process, and implementation of rules and protocols that hospital staff and attending physicians must follow. The sophisticated readers of this column are well-aware of many of the daily ways the trust in attending physicians manifests itself – but, the most dynamic may be keeping abreast of the evolving standard of care for each specialty.

Modern treatment offers an impressive array of developments, which allow us to provide ever better treatment to our patients. What was a complicated surgical years ago, in many instances is now a routine procedure. Of course, many of these advancements have been enabled by medical engineering. These advancements, however, pose new risks.

Emerging technology has been widely adopted by the general population. For example, many of your patients may request a laparoscopy when an open procedure would be more medically appropriate. The psychology behind this is obvious – we trust technology, and who would not desire a more minimally evasive procedure? We would rather a short recovery rather than a more prolonged convalescence.

We know that when it comes to consent to any surgical procedure - the buck stops with the patient. However, invoking the educated trust placed in our attending surgeons, risk managers must put into place proper rules and protocols to ensure that patients at their facilities are given complete and thorough accounts of the risks, benefits and alternatives to every procedure. For example, a patient should be made aware that while they may prefer a laparoscopy, an open procedure may be indicated.

Today's column focuses on another emerging area – robotic surgery. Are your patients being advised of the risks, benefits and alternatives to robotic prostatectomy procedures? To what extent are they being educated of the comparison to traditional open prostatectomy procedures?

BACK TO THE FUTURE

Prostate cancer is prevalent in the United States. In fact, it is the sixth most common cancer in the world, and the most common non-skin cancer in the United States.

In all, it totals 30% of all male cancers yearly. Luckily, modern medicine has developed advanced means of detecting this malignancy when it is still treatable, if not curable.

Once diagnosed with prostate cancer, treatment options also abound. These include radical prostatectomy, radiation therapy (including external beam and/or brachytherapy), or the most conservative treatment- monitoring.

While the confluence of emerging technology and medical advances have made detecting prostate cancer more successful, it has also opened the door to more options in terms of performing the radical prostatectomy. These include the more common retropubic and perineal approaches, as well as the minimally invasive robotic or laparoscopic surgery.

However, with these developments comes some confusion. For example, the 2007 American Urological Association guidelines concluded that the available data was insufficient to recommend any one form of treatment over the others for any risk category of prostate cancer. The National Comprehensive Cancer Network is similarly unable to give any definitive treatment recommendations.

While long-term prognosis and accompanying considerations exceed the scope of this article, it is worth briefly summarizing the available invasive surgical options:

RETROPUBIC PROCEDURE: Depending on the nature of the mass, erectile function may be lost as a result of this open procedure. Patients normally ambulate on the evening of the surgery. Most patients are discharged after 48 hours. Staples are removed 5-7 days later. 70% of men undergoing this procedure for clinically localized disease have control over the disease for at least 10 years.

The most concerning complications from this surgery are usually impotency and urinary incontinence. While complete incontinence is uncommon, most men do experience stress related incontinence after this surgery. This is estimated to be 88-100% at 6 to 24 months. However, studies suggest that 95% of men regain continence after 24 months. Potency is more varied, and factors such as age and prior health must be considered. But, at least one study indicated that after two years, 62% of men had regained potency.

ROBOTIC OR LAPAROSCOPIC RETROPUBIC PROCEDURE: This alternative to the open procedure uses a smaller incision and use of magnification of the operative field for the operator. It is postulated that there are fewer complications and quicker recovery. From 2003 to 2007, those choosing this approach increased from 9% to 43%. However, is this surgery truly safer?

Evidence suggests that while this surgery does decrease hospital stay, there may be a significant increase in incontinence and erectile dysfunction. Even more concerning, there is conflicting data regarding whether or not there is a higher rate of positive surgical margins following these more minimally invasive procedures.

Studies suggest that these complications may merely be due to the fact that surgeons are simply not experienced enough. There is a significant learning curve associated with the robotic and minimally invasive procedures, and at least one study estimated that it may take 200-250 cases to reach a plateau in expertise.

PERINEAL RETROPUBIC PROCEDURE: This approach may be a reasonable alternative to the more common retropubic procedure. Essentially, identical recovery time, survival rate and incontinency recovery have been reported. Although, the recovery of potency is less common when compared with retropubic procedure.

REAL WORLD APPLICATION

Applied to risk managers, this data is illuminating. Whereas, many patients would prefer minimally invasive radical prostatectomy procedures, there is evidence that they pose more post surgical complications than an open procedure.

As a result, measures should be taken to ensure that patients are made aware of the greater potential for incontinence and erectile dysfunction. While these complications surely are of concern to male patients, the potentially bigger threat is incomplete margins.

Patients should be explicitly made aware of the potential for these complications, and the fact that the risk factors are arguably less in open procedures. It is recommended that this be put in writing and acknowledgments executed by patients prior to the surgery. While the task of explaining the risks, benefits and alternatives rests on the attending physician under New York law, in many instances hospitals and surgical facilities are held vicariously liable and may be forced to defend claims that could have easily been avoided with proper presurgical informed consent.

A stickier issue is the question of experience. As set forth above, many of these complications inherent to the robotic and laparoscopic procedures may be attributable to the inexperience of the surgeons. Attending surgeons may balk at the idea of informing patients of their experience or lack thereof in performing specific surgical procedures. On the other hand, hospitals may limit privileges and force surgeons to have mentors or more experienced surgeons accompany them until they obtain a plateau of experience.

CONCLUSION

Advancements empower medical practitioners to offer treatment that appeared out of reach just a short while ago. However, these advancements are not always superior to more tested practices. Patients must be made aware of risks, benefits and alternatives, and practitioners must be properly trained to adequately wield the advancements available to them.

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Ari Erlichman is associated with Bower Monte & Greene, P.C. He is a 2011 graduate of Georgetown University Law Center, where he was a member of the moot court and 2010 recipient of the Cali Award given for highest course grade. Since recently joining the firm, Mr. Erlichman has focused his practice on defending medical malpractice and long-term residency claims. During his off-time, Mr. Erlichman enjoys spending time with his wife and two toddlers.

TELEMEDICINE

By: Andrew I. Kaplan

On July 5, 2011, the new Centers for Medicare and Medicaid (CMS) Rules for Hospital and Critical Access Hospital Conditions of Participation (COP): Telemedicine Credentialing and Privileging went into effect. These rules superceded the prior Joint Commission (TJC) recommendations and revised the former COPs, ostensibly in an effort to relieve what was perceived to be undue hardship in obtaining credentialing and privileging for each distant site physician and practitioner providing services to an originating site. While the new rules do, in fact, ease the originating site's credentialing burden by allowing it to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity, these new rules are, nonetheless, fraught with peril for any originating Hospital's Risk Manager or Governing Board.

WHAT IS TELEMEDICINE?

CMS defines telemedicine as the provision of clinical services to patients from a distance via electronic communications. Telemedicine is the ability to provide interactive healthcare utilizing modern technology and telecommunications. Basically, Telemedicine allows patients to visit with physicians live over video for immediate care or capture video/still images and patient data are stored and sent to physicians for diagnosis and follow-up treatment at a later time. The distant site telemedicine physician or practitioner (the consultant) provides clinical services to a hospital or critical access hospital (CAH) either simultaneously - i.e., in real-time, similar to an in-person consultation - or non-simultaneously, as an after-the-fact interpretation of diagnostic tests in order to provide an assessment of the patient's condition, such as a radiologist who interprets a patient's studies and reports their findings back to the patient's attending physician.

It is important to note, however, that CMS specifically excludes informal consultation among practitioners or the provision of professional consultation services (the informal request for specialist consultation or opinion) from one attending to another from its new rules. CMS does not seek to stifle the informal exchanges that occur on a daily basis between physicians in the hallway, via email, or telephone as they promote safe, effective care for patients.

THE OLD RULES

Under the prior COPs, the governing body of the hospital was required to make all privileging decisions based upon the recommendations of its medical staff after the medical staff had thoroughly examined and verified the credentials of each and every practitioner applying for privileges, and after the staff had applied specific criteria to determine whether an individual practitioner should be privileged at the hospital, regardless of whether services would be provided in person and onsite or remotely through telecommunications.

This resulted in the formation of "affiliative staffs" of outside physicians who were technically members of a hospital's medical staff without any specific clinical privileges. The new rules now allow for "telemedicine staff," which would permit privileges in telemedicine to be granted without inclusion on the medical staff.

Under its previous statutory deeming authority, TJC permitted "privileging by proxy," which had allowed TJC-accredited hospital to privilege "distant-site" physicians and practitioners by allowing one TJC-accredited facility to accept the privileging decisions of another TJC-accredited facility utilizing a streamlined independent determination process, rather than making an individualized decision based on the practitioner's credentials and record. CMS felt this method often did not meet with CMS credentialing requirements, and now requires TJC to conform its accreditation program to the Medicare requirements (which it has done by standards generated on 7/18/11), including the provisions governing credentialing and privileging, and enforce them at all their accredited hospitals.

So, under the old rule the governing body of the Hospital or CAH was required to make all privileging decisions based upon the recommendations of its medical staff after a thorough independent examination of each and every applicants request for privileges whether providing services in person or remotely, without the right to rely on the credentialing already undertaken by the practitioner's outside or prior facility. This resulted in duplicative credentialing, burdensome efforts and conflicts with TJC's "privileging by proxy" provisions which allowed a TJC-accredited facility to accept the decisions of another.

THE NEW RULES

The new rules permit a governing body of a hospital or CAH to rely on credentialing and privileging decisions made by distant-site hospitals or telemedicine entities when privileging practitioners for telemedicine services, as long as certain conditions are met. Distant-site Hospitals are Medicare-participating hospitals providing the consulting practitioner. Distant-Site Telemedicine Entities can include non-Medicare participating hospitals or entities established specifically for the provision of telemedicine services to hospitals and CAHs.

To rely on a distant-site hospital's credentialing and privileging decisions, the hospital or CAH **must have a written agreement** that establishes the following:

1) The distant-site hospital is a Medicare- participating entity;

2) The distant-site practitioner is privileged at the distant-site hospital as evidenced by a current list of the practitioner's privileges provided by the distant-site hospital;

3) The distant-site practitioner holds a license issued or recognized by the State in which the hospital or CAH whose patients are receiving telemedicine services is located; and,

4) The hospital that credentials and privileges the distant-site practitioner shares the practitioner's performance review information (adverse events, complaints, internal reviews).

In contracting with a distant-site telemedicine entity, as opposed to a distant-site hospital, the originating hospital also has the obligation of establishing that the entity's credentialing process meets CMS standards; that the distant-site practitioner has the experience and expertise represented

by the entity; that the practitioner holds a license in the State in which the hospital or CAH is located and that the hospital or CAH obtains the practitioner's thorough performance review.

On the issue of informed consent, CMS relies upon existing medical staff procedures and applicable State and Federal Law to proscribe the manner in which informed consent will be obtained and required in telemedicine. In other words, so long as the distant-site practitioner is providing services, there is no difference between distant-site or in-house requirements. If they provide treatment that, under medical staff policy or State law, requires informed consent, then consent must be obtained, whether the treatment is furnished through telemedicine or not. If consent is not customarily required on-site, then it would not be required when the telemedicine practitioner performs the same services.

WHAT IT ALL MEANS

While attempting to streamline the process and relive the credentialing burden from the originating site's medical staff, the new CMS rules carry with them the potential for myriad policy, performance, privilege and liability issues for the originating site hospital and distant site entity.

Whereas the governing board of a hospital customarily relies upon the recommendations of its medical staff in hiring and credentialing physicians, in the telemedicine arena they will be relying upon the due diligence of an outside entity and their knowledge of that practitioner. This shift in credentialing responsibility brings with it a series of new responsibilities and concerns. Rather than review the candidate, the credentials committee will now review his or her application and the distant site facility's disclosure prior to approval. Whether reliance upon the distant site entity's due diligence will protect the originating site from liability for the distant site practitioner's alleged malpractice or misconduct or whether it will expose the originating site hospital to a negligent hiring, retention and/or supervision claim remains to be seen. Consideration must be given to building indemnification or hold harmless clauses into telemedicine agreements but the question remains as to whether they will be deemed legally valid. These are all questions that can only be answered in time, but which must be discussed by the originating site's Governing Board and its counsel prior to engaging in any telemedicine agreements under the new rules. The appropriate liability and privilege protections will have to built into any agreement.

Likewise, there will, by law, have to be a level of disclosure and communication shared between originating and distant site facilities as it pertains to the distant site practitioner's performance reviews. How that information can be shared without violating hospital and State quality assurance or privilege laws will have to be discussed and included in the telemedicine bylaws and the site to site arrangements. Who owns the privilege under these circumstances and who has a duty to protect it will have to be managed on a case by case basis.

There is no question that any participating facility will need to address changes in its Medical Staff bylaws as they pertain to Telemedicine, particularly whether there will be a new standard for Telemedicine, or whether it will fit into existing categories on a case by case basis (Radiology, Dermatology, etc). Any staff policy that requires the "physical presence" of a physician may have to be altered to consider telecommunication and evaluation, and issues regarding reimbursement, HIPAA compliance, billing and insurance coverage issues (Directors and Officers, General Liability and malpractice) will have to be addressed.

Eventually, there may be a National licensing standard applicable to all 50 states as it pertains to telemedicine (New York has a bill under consideration), but at present there are widely disparate regulations from state to state. What regional standard of care eventually applies to telemedicine treatment will also have to be addressed, as by its very nature the typical "community standard" no longer applies when the community no longer has geographical boundaries.

For now, we would suggest that any written agreements for telemedicine services should outline the specific responsibilities of the telemedicine provider's governing body or other responsible decision-makers in terms of internal review and credentialing of practitioners and the provision of services, along with all of the aforementioned provisions of the new COPs. Whether the originating hospital will still be "responsible" for the care remains to be seen, but there should be direct inquiry by the "home" hospital as to whether the distant site is a Medicare provider; whether a list is maintained of credentialed providers for telemedicine services, and that the distant site regularly reviews the services provided by those providers for quality and safety.

The originating site should review these agreements with counsel to ensure they contain adequate warranties of representation when a distant site subcontracts; proof of liability insurance on both ends of the agreement; indemnification and risk-sharing provisions; and a right to review agreements that might be made between the distant site entity and any subcontractors it enters into arrangements with to ensure the same level of scrutiny is being applied by the subcontractors to the quality and service of their providers. The originating site hospital should set up provisions to monitor the distant site practitioners and perform internal reviews of the distant site practitioner's performance and privileges regularly. Updates and appraisals should be shared with the distant site and should include all known or reported adverse events and any and all complaints the hospital has received regarding the practitioner.

Myriad other issues for the originating site's medical staff and governing body are certain to arise – the sharing and protection of confidential information and who should have access to it; whether a telemedicine entity will be considered a recognized peer review body such that the applicable state or federal privileges will attach to shared information with such an entity; what types of hearing rights if any a practitioner will possess under medical staff bylaws or state law for telemedicine care; whether hospitals will want to set up entire telemedicine departments for the collection, monitoring and storage of telemedicine treatment and practitioner review data or for the establishment and administration of that care.

For those hospitals currently embarking upon this endeavor, however, it is enough to digest the new COPs and to ensure, at minimum, that any originating or distant site hospital is complying with them before entering into any covenants for the provision of telemedicine care. As with any new or developing area of medicine, all of the ancillary issues will develop over time, perhaps through trial and error and perhaps through litigation, but for now any hospital Board that intends to pursue telemedical care must give consideration to all of the existing and potential ancillary issues and not only address them, but plan for them by drafting adequate protections of their own interests and those of their patients.

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LEGISLATIVE/LEGAL UPDATE

DISCOVERABILITY OF DOCTOR'S EMAIL IN A QUALITY ASSURANCE SETTING

By Robert D. Martin

Discovery is, as its name implies, an open search for the facts in litigation. The measure of the limits of discovery is broad. The Court of Appeals succinctly provided over 40 years ago as follows:

> The courts do undoubtedly possess a wide discretion to decide whether information sought is 'material and necessary' to the prosecution or defense of an action (citation omitted) but that discretion is not unlimited.[1]

One such limit has been the proscription of use of materials used in connection with a quality assurance review. The New York State Education Law provides as follows:

> Neither the proceedings nor the records relating to performance of a medical or a quality assurance review function or participation in a medical and dental malpractice prevention program nor any report required by the department of health pursuant to section twenty-eight hundred five of the public health law described herein, including the investigation of an incident reported pursuant to section 29.29 of the mental hygiene law, shall be subject to disclosure under article thirty-one of the civil practice law and rules except as hereinafter provided or as provided by any other provision of law.[2]

This issue has resulted in protracted litigation across the state. What is clear is that merely labeling a document as related to a quality assurance function is insufficient. In an action involving quality assurance in a nursing home setting, the Appellate Division for the First Department permitted discovery of negative outcome and incident reports involving conditions and occurrences like those alleged in the plaintiff's complaint, "since such reports, although utilized by defendant's quality assurance committee, were not prepared by or at the behest of such committee, but rather were of the type routinely prepared and maintained pursuant to 10 NYCRR 415.15(a)(3)(i)."[3]

The Hospital or physician seeking the benefit of the privilege bears the burden of establishing the applicability of the privilege. This must be done by establishing that the document or communication was created solely for the quality assurance review function.

This July, Justice Alice Schlesinger, a Supreme Court Judge in New York County (First Department), determined that an email sent by a private attending orthopedic surgeon to the Chief of the Department of Surgery at the hospital commenting on the non-orthopedic care of a patient who died following hip surgery performed by the orthopedic surgeon was discoverable.[4] The undisputed facts in that matter were that the surgeon performed hip surgery on an 89 year old patient who subsequently died. The surgeon was critical of the post-operative non-surgical care rendered at the hospital. The hospital claimed that the surgeon approached the Chief of Surgery, who was a Quality Assurance Board member, and raised his concerns and that the Chief requested the surgeon to write him an email in anticipation of a quality assurance review. The surgeon disputed the claim and claimed instead that the email was for informational purposes and was not created for a quality assurance review.

The Chief of Surgery provided by affidavit that he distributed the email to another member of the Quality Assurance Board and to no other. The document was then filed in the Quality Assurance Control Department. By contrast, the surgeon affirmed that the email was distributed to the Surgical Residency Director and the Chief of Orthopedic Surgery, in addition to the Chief of Surgery.

Judge Schlesinger, in a detailed decision, opined that the privilege protecting documents of this type is a narrow one. She reaffirmed, citing a 1998 Court of Appeals decision, that the purpose of the privilege is to "enhance the objectivity of the review process" and to permit frank discussion in keeping with the legislative purpose behind the Education Law.[5] Justice Schlesinger set forth a two-part test to be established in evidentiary form: (1) the document must have been created for the purpose of quality assurance and at the behest of the Quality Assurance Board; and (2) it must have been used for that purpose. Where the document is created for a regulatory or administrative function, such as the negative outcome reports as discussed above, the standard for maintaining the privilege is not met according to Judge Schlesinger. She continued that even if the Quality Assurance Board member "approached" the surgeon to write the email to express his concerns, where it was not shown that the email was created for the exclusive use of the Quality Assurance Board, the privilege did not apply.

The bottom line is that the privilege accorded quality assurance documents is limited. Quality Assurance reviews provide a vital and important forum to discuss care of patients under circumstances of negative outcomes to provide lessons to improve patient care. However, in order to protect that privilege and that function, the courts require that facilities undertake affirmative steps to protect that privilege.

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[1] Allen v. Crowell-Collier Pub. Co., 21 N.Y.2d 403, 406, 235 N.E.2d 430, 432 (1968)
[2] N.Y. Educ. Law § 6527(3)(McKinney 2001 and 2011 Supp.)
[3] Clement v. Kateri Residence, 60 A.D.3d 527, 527-28, 875 N.Y.S.2d 66, 67-68 (2d Dept 2009)
[4] "Doctor's Email Is Fair Game In Lawsuit, Judge Finds," NYLJ, August 22, 2011 at page 1.
[5] Logue v. Velez, 92 N.Y.2d 13, 17(1998)

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CURRENT STATE OF THE LAW:
WHAT IS A STILLBIRTH AND WHEN CAN THERE BE A RECOVERY?

By Robert D. Martin and Amanda Perry[1]

To most people, if not everyone, there can be no greater loss than the loss of a child. Legislatures and courts across the country have been grappling with the legal aspect of determining how to handle the loss of a child for decades. In the State of New York, the issue of a loss of a child has largely been left to the court system. This article will examine the current state of the law.

Definitions

New York State Public Health Law defines live birth as follows:

> Live birth is defined as the complete expulsion or extraction from its mother of a product of conception, irrespective of duration of pregnancy, which, after separation, breathes or shows any other evidence of life such as a beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered a live born.[2]

The United States Department of Health and Human Services Centers for Disease Control and Prevention defines a live birth as:

> The complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Heartbeats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from leaking respiratory efforts or gasps.[3]

In another 25 states, it is a condition precedent that the pregnancy must equal or exceed 20 weeks. Another 12 states require that the birth weight must equal or exceed 350 grams or a gestation of 20 or more weeks.

The National Institutes of Health report that, as of November 2010, stillbirths occur in nearly one in 200 pregnancies in the U.S. per year. Often, healthcare providers can find no cause for the pregnancy loss.[4]

Legal Analysis

The Court of Appeals for the State of New York established that an infant-plaintiff has no right of action unless born alive and, concomitantly, liability for *in utero* injuries does not exist unless and until there is a live birth.[5]

The issue then arose as to the determination of the meaning of being born "alive." The Court of Appeals defined being alive as "capable of being delivered and of remaining alive, separate from its mother."[6]

In 1985, the Court of Appeals held that a mother could not recover for emotional injuries where medical malpractice caused a stillbirth or miscarriage absent a showing that she suffered an independent physical injury that was both distinct from that suffered by the fetus and not a normal incident of childbirth.[7]

In the late 1990's and into the early 2000's plaintiff's attorney Margaret Jasper undertook a mission to broaden the right of recovery. She was partially successful. Initially, she attempted to file for Limited Letters of Administration in the Surrogates Court for the purposes of commencing a cause of action on behalf of a stillborn. The fetus in question was born by cesarean section and an autopsy report indicated that the fetus died of placental abruption prior to delivery.[8]

At or about the same time, Ms. Jasper prosecuted a similar action involving the delivery of a stillborn and the Appellate Division for the Second Department dismissed all causes of action that in one way or another sought recovery on behalf of the stillborn.[9]

The Court of Appeals in April of 2004 rendered opinion in part reversing the Second Department. The Court of Appeals held that:

> Even in the absence of an independent injury, medical malpractice resulting in miscarriage or stillbirth should be construed as a violation of a duty of care to the expectant mother, entitling her to damages from emotional distress.[10]

Justice Read, in his dissent, noted that this potentially exposed healthcare providers to the potential for an unpredictable extension of liability and cost effecting the availability of gynecological and obstetrical services in the State of New York.[11]

Approximately one year after deciding Broadnax, the Court of Appeals had another opportunity to consider the issue. The Court of Appeals reviewed a matter in which an expectant mother was advised by her obstetrician and a consulting obstetrician that because of an underlying condition involving the presence of uterine fibroids, she would either naturally miscarry or have a severely damaged infant. She alleges to have been advised to undertake treatment with Methotrexate to medically cause a termination of pregnancy without the trauma of having to undergo surgery at or about the seventh week

of pregnancy. At the 28th week of pregnancy, she learned that the termination of pregnancy had been unsuccessful and that she remained pregnant. She elected to carry the infant to term and the infant was born severely impaired. The causes of action were brought on behalf of the infant for *in utero* injury and for the mother relating to emotional damage allegedly sustained as a result of the injury to the fetus *in utero*. However, the Court held that the mother may not maintain a cause of action for emotional harm relating to the alleged medical malpractice causes of action for *in utero* injury to the fetus where the infant is subsequently born alive. The Court essentially argued that the purpose of providing such a cause of action under Broadnax was limited to the circumstances where the cause of action will be completely extinguished because there would be no person to carry the cause of action where the infant was not born alive.[12]

The question then arose as to what occurs if the baby is injured *in utero*, is born alive and then dies shortly after birth. A trial court in St. Lawrence County attempted to deal with this difficult question by applying the Sheppard-Mobley decision narrowly and finding that if the infant is born alive, regardless of how long the infant survives, the cause of action for emotional distress is extinguished.[13]

More recently, the Appellate Division for the Second Department had occasion to consider a case wherein evidence was adduced that an infant was born alive and generated a heart rate of more than 100 beats per minute within 22 minutes of delivery. However, the infant was apparently ventilator-dependent and was reported as having APGAR scores of 0 at 1 minute, 5 minutes and 10 minutes. The Appellate Division for the Second Department held that the plaintiffs raised an "issue of fact" as to whether the fetus was stillborn or born alive.[14]

The intent of plaintiff was to establish that the infant was stillborn for purposes of seeking the recovery for emotional harm allegedly sustained by the mother. If the infant is deemed born alive, the mother would be denied recovery under Sheppard-Mobley and the recovery would be limited to pain and suffering sustained by the infant, if any established.

The issue was also considered in the Supreme Court, Bronx County where the trial court found that, even though an infant was technically born alive, the court found no evidence of consciousness or awareness after birth and found that there was no cause of action in the opinion of the court for conscious pain and suffering such that the infant was not deemed born alive.[15] This decision, if followed has potential far-reaching implications with regard to the extension of liability for damages.

While this decision is not binding, it is illustrative of a point of view within the courts of this State. On November 17, 2009, the same date that the decision in Amin was handed down by the Second Department, Justice Billings of Supreme Court, Bronx County handed down a decision in a matter considering a claim advanced that an infant was stillborn, or, in the alternative born alive, as well as a concomitant loss of services claim for the mother related to the loss of the infant. The court found that the plaintiff was able to plead a claim of stillbirth even where there was a finding of a low heartbeat at 10 minutes, but dismissed all claims for loss of services to the parent based upon the short life span of the infant.[16]

The question then arises as to how does one value this emotional loss allegedly sustained by a mother derived from the birth of a stillborn. Following Broadnax, a trial court in Brooklyn did not upset a verdict of a jury that valued such a loss at $1,000,000 for past pain and suffering.[17] This issue has not been the subject of appellate review to date.

CONCLUSION

The issue of the claim related to a stillbirth is certainly an emotionally charged and unsettled circumstance. It is well-settled law that, prior to birth, no cause of action may be maintained on behalf of a fetus for any injury sustained *in utero*. If indeed there is a stillbirth, the mother may maintain a cause of action for emotional injury related to the stillbirth. She is still required to establish a claim of malpractice causing the still birth as a result of care while the fetus is *in utero* to recover.

At the Federal level, Peter King has introduced HR1037, cited as "Stillbirth Awareness and Research Act of 2011" to develop data on stillbirths. However, that analytical tool appears to be languishing in committee.

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[2] N.Y. Pub. Health Law Section 4130(1)

[3] State Definitions and Reporting Requirements for Live Births, Fetal Deaths and Induced Terminations of Pregnancy, Centers for Disease Control and Prevention (1997 Revision) DHHS Publication No.(PHS) 98-1119

[4] HTTP: //www.nichd.nih.gov//womenshealth/research/pregbirth/miscarriage_stillbirth.cfm?renderforprint=1

[5] Endresz v. Friedberg, 24 N.Y.2d 478, 486, 31 N.YS.2d 65

[6] Woods v. Lancet, 303 N.Y. 349, 357, 102 NE2d 691

[7] Tebbutt v. Virostek, 65 N.Y.2d 931, 493 N.Y.S.2d 1010 (1985).

[8] Broadnax, 240 A.D.2d 663, 659 N.Y.S.2d 502 (2nd Dept., 1997)

[9] Politis v. Pritzker, 249 A.D.2d 529, 671 N.Y.S.2d 357 (2nd Dept., 1998)

[10] Broadnax v. Gonzalez, 2 N.Y.3d, 148, 155, 777 N.Y.S. 16, 416 (2004)

[11] *Id*. at 2 N.Y.3d 148, 156

[12] Sheppard-Mobley v. King, 4 N.Y.3d 627, 64, 797 N.Y.S.2d 403 (2005)

[13] Warnock v. Duello, 10 Misc.3d 578, 579, N.Y.S.2d 422 (S. Ct. St. Lawrence Cty 2005)

[14] Amin v. Soliman, 67 A.D.3d 835, 836, 889 N.Y.S.2d 629 (2nd Dept., 2009)

[15] Mendez v. Bhattacharya, 15 Misc.3d 974, 981-82, 83 N.Y.S.2d 378, 385 (S. Ct., Bronx Cty 2007)

[16] Charles v. Suvannavjeh, 28 Misc.3d 1157, 907 N.Y.S.2d 362, 364-365 (Sp. Ct. Bronx Cty 2009)

[17] Ferreira v. Wyckoff Heights Medical Center, 12 Misc.3d 1180 (A)824 N.Y.S.2d 762 (N.Y. Civ. Ct. 2006)

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