AHRMNY

RISK MANAGEMENT JOURNAL



JOURNAL OF THE NEW YORK
RISK MANAGEMENT
CHAPTER OF ASHRM

AHRMNY

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

www.ahrmny.com

RMJ 2022 - VOLUME II

Editor's Corner

AHRMNY's Risk Management Journal (RMJ) is the official journal of The Association for Healthcare Risk Management of New York, Inc. (AHRMNY) and is published several times a year.

RMJ'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 regulation, 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.

CLICK HERE FOR THE OFFICIAL RMJ AUTHOR GUIDELINES

Article Requirements: Maximum article length 3,500 words. Photos should be high-resolution JPEGs (at least 300 dpi); AHRMNY will not publish articles promoting products or services.

The information presented in AHRMNY RISK MANAGEMENT JOURNAL is for educational purposes only.

Questions or comments to editors may be sent to ahrmny@gmail.com

In this Edition . . .

3 President's Message
4 Thank you 2022 Sponsors
5 Memorial Tribute - Alvin Safran
6 Preparing for Litigation Under New York's Adult Survivor Act
9 Grieving Families Act White Paper and Update
21 Call for Speakers
22 Member Spotlight
24 Fourth Department Holds Repeal of EDTPA - COVID-19 Nursing Home Litigation
25 Save The Date - 2023 Evening Networking & Educational Conference
26 Documents Protected from Discovery in Nursing Home Cases
31 Highlights from ASHRM's Annual Conference
32 Highlights from Chapter Event at ASHRM Conference
33 Risk Considerations for Using Surveillance Cameras in Healthcare Practices
34 The Liability Issues of 'Medispa' Treatment
37 Supporting Resilience in Healthcare Workers
40 Article References

PUBLICATIONS COMMITTEE

- Deanna Mirro Altmann
- Judith Block
- Steph Campbell
- Maggie Emma
- Ken Fox
- Linda Foy
- Mario Giannettino
- Jose L. Guzman, Jr.
- Andrea Maestas
- Pamela Monastero
- Ruth Nayko
- Wilhemina Nyarko
- Dawn Pignatelli
- Sharon Scheuermann
- Lori Shapiro
- Samantha Quinn
- Kisha Wright

AHRMNY Invites you to:

BECOME A MEMBER

BECOME A SPONSOR

SUBMIT AN ARTICLE FOR OUR JOURNAL

JOIN A COMMITTEE

SHARE ACHIEVEMENTS IN MEMBER SPOTLIGHT

ADVERTISE IN OUR JOURNAL

PRESIDENT'S MESSAGE



Dear Members:

I am honored and excited to serve as the AHRMNY president during the 40th Anniversary year. This year ASHRM changed our job profession designation from Risk Manager to Risk Professional. Whatever our specific role in risk management, we are all professionals in managing risk, promoting patient safety and improving the care that health care providers and facilities deliver.

Under the leadership of our immediate past President Rob Marshall, we were able to transition from all virtual educational opportunities back to a combination of webinars and live meetings. Our first live event on June 10th on Wall Street was a tremendous success with great talks and a perfect day for a rooftop cocktail reception. Our Chapter event in Boston at the ASHRM annual conference was well attended and allowed for continued networking and collegial conversations.

The Education committee under the leadership of Lori Shapiro has planned many educational opportunities for the 2022-2023 period.

We already had a webinar on the collaboration of Quality & Risk Management. Others are in the planning stages. The Fall half day conference at the DeMatteis Center focused on de-escalation, security, and professionalism. On February 15th, we will have an evening networking event at Lenox Hill Hospital featuring 30 minute round tables discussions like speed dating, so you can go to several topics that pertain to your interest.

Early June we are planning the annual conference with a full day of networking and a robust educational program.

AHRMNY represents all of New York yet upstate membership is limited. We are exploring to offer educational meetings outside of the metropolitan area. The first exploratory meetings have occurred and it looks like Saratoga will be the first AHRMNY conference (official date TBD).

On behalf of the entire Board, we want to thank the following sponsors for their generous support of our 2022 Educational Programs.

Best,
Victor

2022 SPONORS

Platinum

M2 LIABILITY SOLUTIONS
Representing MLMIC & MedPro Group
Berkshire Hathaway Companies

EMPRO INSURANCE

VBPNP
VIGORITO, BARKER, PATTERSON, NICHOLS & PORTER, LLP

The Doctors Company
TDCGROUP

Gold

kbr
KAUFMAN BORGEEST & RYAN LLP

RUBIN PATERNITI GONZALEZ RIZZO KAUFMAN

Silver

BBO&C
BARBIERO BISCH O'CONNOR & COMMANDER LLP

FUMUSO, KELLY, SWART, FARRELL, POLIN & CHRISTESEN LLP

MCB
MARTIN CLEARWATER & BELL LLP

Bronze

AARONSON RAPPAPORT
Aaronson Rappaport Feinstein & Deutsch, LLP

BARTLETT LLP

MLN
MAURO | LILLING | NAPARTY LLP

LEWIS JOHS
Lewis Johs Avallone Aviles, LLP

kbr
KAUFMAN BORGEEST & RYAN LLP

SHAUB AHMUTY CITRIN & SPRATT

FUMUSO, KELLY, SWART, FARRELL, POLIN & CHRISTESEN LLP

USI

RUBIN PATERNITI GONZALEZ RIZZO KAUFMAN

Exhibitors

Ansell

Advizex

SafeQual

TAYLOR HEALTHCARE

IN LOVING MEMORY



The Association for Healthcare Risk Management recently announced the passing of our dear friend and colleague Alvin Safran. We were so moved with all the heartfelt responses received from those who knew and worked with Alvin that we wanted to share these caring notes with all the members in this special tribute.

Alvin passed away on October 31, 2022. It was relayed through a close friend that Alvin did not wish to have a large funeral service. Many of us were able to spend time with Alvin this past June at AHRMNY's annual conference and again in August at AHRMNY's president's dinner.

Alvin was a long time member and advocate of AHRMNY and also an active member of the national risk management organization (ASHRM). In 2003, Alvin joined the AHRMNY Board and served in various roles from President, President-elect, Board of Director, Chair of membership and public relations committees, and eventually Emeritus Director.

Alvin was a creative thinker, one not afraid to "think out of the box" and this led to some amazing improvements within the organization that are still in effect today: implementation of the revolving membership, creation of the Emeritus Director role, creative conference formats (mock trial), and institution of video recording of educational programs.

There's so much to say about Alvin but no one could say it better than those who knew him well. We invite you to take a few moments to reflect on these beautiful, heartfelt notes:

"Alvin loved to sing and dance and I played the piano. We performed at the Lang Auditorium at NY Hospital of Queens and raised a lot of money for the hospital. Alvin loved to travel and cruising in particular. He was able to travel to many places."

"Alvin nominated me for a position on the AHRMNY Board many years ago. He was a true professional and a great pleasure working with him when he was at NY Hospital Medical Center of Queens."

"Alvin was such a great role model to the profession and willing to help out at every turn."

"Alvin was simply the best."

"Alvin was a brilliant man and had a brilliant personality and shared it with warmth and a smile."

"Alvin was the very first risk manager I ever met."

"Alvin was very empathetic and authentic."

"Alvin was the reason I joined AHRMNY and he always served as a role model for risk managers."

"I have known Alvin since 1992 when a group of Queens Risk Managers got together monthly to support each other. It was uncanny how Alvin was always the first person I would see at the annual ASHRM conference, either at the airport or hotel. He was a fun and beautiful soul that could light up a room."

"His smile will be forever remembered."

"Alvin was an advocate for patient safety and AHRMNY. His wisdom, humor, and outsized personality will be missed."

"A tremendous loss."

Preparing for Litigation Under New York's Adult Survivors Act

By Karen L. Campbell and Corey L. Shulman

On May 24, 2022, New York Governor Katherine Hochul signed the Adult Survivors Act ("ASA") into law. Similar to New York's Child Victims Act of 2019 ("CVA"), the ASA will temporarily revive claims for injuries resulting from sexual abuse or assault, regardless as to when the abuse or assault occurred. Attorneys who specialize in representing plaintiffs are already launching vigorous advertising campaigns on television, the internet and social media. These campaigns focus on pursuing claims against high-profile abusers, including those in powerful positions or employed by financially stable companies. They are presumably interviewing potential plaintiffs and are drafting complaints to file immediately after the ASA window opens. We expect ASA claims to target deep-pocket or well-insured defendants, rather than uninsured individuals (such as family members, friends, or current or former spouses/romantic partners). In order to prepare insurers, insureds, risk managers and attorneys for a flood of litigation in 2022 through 2023, this article will (1) summarize the ASA; (2) draw parallels between the ASA and the now-heavily litigated CVA; (3) identify anticipated causes of action and defenses; and (4) provide helpful suggestions to identify and limit potential liability before the ASA goes into effect.

I. What is the ASA?

Sponsored by New York State Senator Brad Hoylman and Assemblymember Linda Rosenthal, the ASA was introduced to provide a legal remedy for adult sexual assault survivors while recognizing sexual assault trauma can manifest years after the abuse occurs. Before the passage of the ASA, sexual assault or abuse victims were required to file civil lawsuits as quickly as one year from the date of the assault or abuse.[1, 2] In cases where the defendant was subject to a criminal action involving the same event or occurrence, New York provides plaintiffs with a one-year extension following termination of the criminal action to file a civil claim[3] and a five-year extension in cases involving Rape in the First Degree, Criminal Sexual Act in the First Degree, Aggravated Sexual Abuse in the First Degree, or Course of Sexual Conduct Against a Child in the First Degree.[4] If the defendant was convicted of the crime, the plaintiff has seven years from the date of the crime to file a lawsuit against the defendant.[5] In certain circumstances, such as convictions for a violent felony offense, first degree felony, or a class B felony, the plaintiff has ten years from the date of the conviction to file a lawsuit against the defendant.[6]

Proponents of the ASA recognized New York's statutes of limitations posed several roadblocks for sexual assault or abuse victims. First, the statutes of limitations do not address criminal acts which were never reported or prosecuted. Second, the statutes of limitations made it difficult for plaintiffs to pursue actions against other legally responsible parties, such as employers, principals, or supervisors. Regardless of whether the assault or abuse resulted in a criminal action, a plaintiff was required to commence a civil action against a party legally responsible for the abuser within three years of the abuse.[7] Third, trauma factors such as fear of retaliation, embarrassment, and denial forced plaintiffs to commence a lawsuit before coping with their abuse, or to risk waiving a potential right to civil damages.

As a response to those issues, and codified as Section 214-j of the CPLR, the ASA permits every civil claim or cause of action against any party alleging intentional or negligent acts or omissions by a person for physical, psychological, or other injury or condition suffered as a result of conduct which would constitute a sexual offense as defined in Article 130 of the Penal Law (sex offenses) against a person who was 18 years or older or incest as defined in Section 255.26 or 255.27 of the Penal Law against a person who was 18 years old or older. As discussed below, the ASA permits plaintiffs to bring these lawsuits even if the alleged sexual offense would be considered time-barred under the operative statute of limitations.

The ASA went into effect on November 24, 2022 and will expire one year thereafter (or Friday, November 25, 2023).

II. Parallels between the ASA and the CVA

The ASA follows a similar statutory scheme to the CVA (enacted on August 14, 2019 and expired on August 13, 2021). The CVA (codified as Section 214-g of the CPLR) permitted plaintiffs to file lawsuits alleging intentional or negligent acts as a result of conduct which would constitute a sexual offense as defined in Article 130 or Section 263.05 (use of a child in a sexual performance) of the Penal Law against a child less than 18 years of age. During the life of the CVA, the New York State and federal courts saw between 9,000 and 10,000 lawsuits alleging sexual abuse or assault suffered as children.[8] In order to bring a claim under the CVA, the alleged abuse must have occurred within the borders of New York State.[9] We anticipate the Courts will require ASA plaintiffs establish the abuse occurred within New York State's borders.

While the CVA and the ASA permit lawsuits against the alleged abuser directly, the acts also permit plaintiffs to allege negligence against entities who exercised some degree of control over the alleged abuser. The CVA prompted plaintiffs to name religious institutions, schools, afterschool programs, youth groups, medical providers, hospitals, foster care programs and many other entities as defendants (this list is far from exhaustive). Plaintiffs primarily alleged these entities were negligent in the hiring, supervision, retention and training of the alleged abuser. Under a theory of general negligence, Plaintiffs also alleged these entities knew or should have known of the alleged abuse, but took no action to stop it.

We anticipate ASA plaintiffs will follow the same scheme of allegations in their Complaints. Risk managers and employers should be aware they are not immune from allegations of liability. ASA plaintiffs will not only pursue high-profile abusers, but will also pursue companies and institutions, alleging an employee, executive or officer violated their positions by abusing the plaintiffs, even if the abuse occurred decades earlier. The ASA will expand named defendants to all places of employment, including universities, medical facilities (including, hospitals, nursing homes and private practices) financial institutions, insurance companies, entertainment and media companies, sports franchises, and religious institutions, to name a few; essentially, the ASA will target any institution or corporation where alleged abuse occurred.

Like the CVA, the ASA provides plaintiffs a trial preference under CPLR § 3403. However, this provision has proven unrealistic in many jurisdictions, particularly downstate courts. Counties such as New York, Bronx, Kings (Brooklyn), Queens, and Richmond (Staten Island) cannot expedite these cases due to bankruptcy filings, extensive pre-answer motion practice, and the sheer volume of cases filed.[10] Adding a deluge of similar cases under the ASA will simply overwhelm the court system further. Thus, we do not anticipate the Courts will push ASA cases quickly towards settlement or trial and the statutory trial preference will be irrelevant for several years.

III. Anticipated Claims and Defenses in ASA Actions

It is sound case law in New York that an employer cannot be held vicariously liable for employees who commit sexual abuse or assault.[11] A cause of action for vicarious liability under the ASA will likely be met with swift dismissal. However, as we saw in CVA cases, the theories of liability are more intricate than simply holding a defendant responsible for its employee's actions.

Negligence is typically the foremost cause of action in CVA cases, and the ASA will be no different. Using an actual and constructive knowledge standard, an ASA plaintiff will allege defendants knew or should have known of the abuser's propensity to sexually abuse the plaintiff, yet did nothing to prevent it. This "knew or should have known" theory is often the crux of plaintiff's case. From our experience in CVA matters, a negligence cause of action almost always withstands a motion to dismiss, as the Complaint typically pleads enough facts to establish a potential claim. Defending this cause of action will depend on whether the defendant had prior notice of the alleged abuser's "propensity" for sexual abuse, including whether the defendant or its employees witnessed the abuse or obvious signs of abuse.

The second major cause of action is negligent hiring/retention/supervision/training. ASA plaintiffs will allege defendants were negligent in hiring, supervising, retaining and/or training the alleged abuser. As this is a multi-faceted cause of action, it often survives a motion to dismiss. For example, if the alleged abuser's employment file establishes he or she had no known criminal history or claims for sexual misconduct at the time of the employment, there is little merit to allegations that the defendant was negligent in hiring the alleged abuser. However, other elements of the claim rest on the defendant's policies and procedures for identifying and reporting sexual abuse or assault. Finally, evidence that a defendant continued employing an alleged abuser even after learning of sexual assault (or turning a blind eye to telltale signs) can constitute negligent retention. For example, during the "Me Too" movement, not only have we have seen countless lawsuits against high-profile/powerful members of the sports, entertainment and media industries, but also lawsuits against major industry corporations alleging negligent retention.

Plaintiffs may allege other variations of negligence against non-abuser defendants, including negligent infliction of emotional distress, intentional infliction of emotional distress, and premises liability. New York Courts have repeatedly dismissed these causes of action in CVA cases as duplicative of negligence and negligent hiring/ retention/supervising/training claims.[12] Breach of fiduciary duty has mixed results, with a split in Courts on whether it is duplicative of negligence.[13]

IV. Tips and Recommendations to Prepare for Claims

Although we anticipate a flood of litigation under the ASA starting in late November 2022, there are several steps potential defendants (and their insurers and risk managers) can take to limit exposure or address liability before the ASA takes effect.

Locate and Secure all Historical Insurance Policies

Entities should ensure they can obtain copies of current and past liability insurance policies. If the entity used a broker to procure insurance for several years, it is a good idea to have the broker locate and preserve all liability policies. Once an entity is served with a Summons and Complaint under the ASA, it is critical to know whether its insurer will defend and/or indemnify against the allegations, or if it must defend the action out of pocket.

Locate all Historical Human Resources Records

Entities should take time to ensure employee files (including background checks) are saved and stored in an organized fashion. In the event an ASA plaintiff names the entity in a lawsuit or the entity receives a subpoena to produce records, it can efficiently locate crucial documents and comply with court directives without delay. For larger companies such as multinational corporations, a routine practice of storing files digitally may be the norm. For smaller businesses, employee files should be easily accessible either on-site or off-site. This includes locating and preserving employee incident or misconduct reports, files prepared by human resources, files maintained by risk management, investigation files, board meeting minutes, and in house (or outside counsel) files for non-privileged documents.

If the entity locates incident reports or records establishing potential liability, it should turn them over to private counsel or its insurance carrier immediately. If counsel advises, the entity may wish to prepare lists of employees involved in the prior incidents, including contact information or last known addresses.[14] These cases can involve claims dating back decades, so the ability to locate potential notice witnesses and/or eyewitnesses can tremendously aid in the defense.

Locate any Prior Lawsuits and/or Settlements

The entity should take an accounting of prior sexual harassment or discrimination lawsuits under Title VII of the Civil Rights Act of 1964 or New York City's Human Rights Law. If the entity has been previously named as a defendant in such a lawsuit, it should contact its employment counsel immediately. Besides the fact that prior counsel likely has records or materials critical to the claims alleged in the ASA action, counsel may have an executed Settlement and Release with an ASA plaintiff from a previous sexual harassment/discrimination claim. While we have not encountered this in CVA actions, a prior Settlement and Release may bar a plaintiff from commencing an ASA action, and can serve as a basis for pre-answer dismissal under CPLR § 3211(a)(5).

Conclusion

The ASA is sure to create extensive litigation in both New York state and federal courts. With tremendous backlog stemming from the COVID-19 pandemic and the thousands of CVA cases in litigation, entities should expect ASA litigation to take several years. As in all litigation, the best defense is early and adequate preparation. Be proactive and prepare for ASA litigation. At the very least, use this valuable time to assemble your company's insurance coverage before the company is served with a summons and complaint. The element of surprise is a risk manager's and attorney's worst enemy. The earlier and more thorough entities are in identifying potential ASA plaintiffs through prior complaints or lawsuits, the better their attorneys can evaluate the lawsuit's defensibility. In contrast, an entity's failure to locate, organize and produce relevant documents may result in greater exposure to liability, an increased risk of an unfavorable trial verdict and a higher price to pay during settlement.

The enactment of the ASA in New York is likely just the beginning of revived sexual abuse and assault cases in state and federal courts. At least twenty-seven U.S. states and territories have passed a statute reviving expired civil claims for sexual assault or abuse towards minors, much like the CVA.[15] Other states will follow the ASA model and corporate entities, insurers and risk managers must be prepared to address and defend these cases on a national scale.

References on Page 40

About the Authors



Karen Campbell is a Lewis Brisbois partner and trial attorney with 34 years of experience focused on defending, among others, long-term health care providers and other defendant litigants in a variety of matters including professional liability, negligence and sexual abuse/misconduct claims. She currently also represents individual and institutional defendants in Child Victims Act and human sex trafficking cases.



Corey Shulman is a Lewis Brisbois partner who focuses on the defense of home health care agencies, assisted living facilities, nursing homes, worldwide hotel brands, non-profit organizations, and religious institutions in medical malpractice, general liability, premises liability, and negligent hiring/supervision matters. His practice currently focuses on Child Victims Act and federal sex trafficking litigation.

Grieving Families Act
White Paper and Update

By Dylan Braverman, Megan Lawless, and Nicole Varisco

Introduction

The Grieving Families Act ("GFA"), a/k/a Senate Bill S74-A (Hoylman) and Assembly Bill A.6770 (Weinstein) was passed by the New York Legislature and awaits the Governor's signature. As set forth below, the GFA is expected to blow the roof off medical and nursing home liability with an increase of 39.5% in premium and 45.3% in losses.[1]

The Actuarial analysis of the impact of the GFA is startling. The three Commercial Insurance lines most impacted will be medical professional liability ("MPL"), automobile liability, including personal and commercial ("AL")[2] and general liability ("GL").[3] The annual losses to these lines because of the GFA are estimated to be $2.09 billion, or a 12.6% increase to the annual loss and loss adjustment expenses in New York. This will cause a resulting $2.14 billion or 11.1% increase in annual premiums by New York residents and businesses for insurance.[4]

Self-insureds will be impacted even more. It is estimated that self-insured businesses (including many nursing homes and hospitals) will suffer an increase in annual losses of $1.72 billion, equating to a 15.3% increase.[5]

Crucially, the brunt of the impact will fall on Medical Professional Liability. While losses for AL and GL are estimated to rise by 6.9% and 12.3%, respectively, the MPL losses are estimated to explode by 45.3%. This will cause an increase in premiums by the medical and nursing home professions of a whopping 39.5%. AL premiums will increase by 6.9%, and GL premiums will increase by 12.3%.

This White Paper discusses issues facing insurers, litigants, nursing homes, hospitals and healthcare providers when this Bill is signed into law. This White Paper also provides guidance regarding how to calculate damages under the current proposed GFA, as well as defense strategies to minimize those damages. It is not a series of answers; those answers will be provided over years via judicial processes. Instead, this White Paper is designed to stimulate critical thinking.

Background

The current wrongful death statute in New York State is codified under EPTL §5.4 and has been in effect since 1847. Under EPTL §5.4-1, the family and/or estate of a decedent has 2 years to commence a wrongful death claim, barring the exception of certain tolls. *Baez v. New York City Health & Hosps. Corp.*, 80 N.Y.2d 571, 607 N.E.2d 787 (1992). Presently, EPTL § 5-4.3 dictates that the award of damages to the statutory distributees in a wrongful death action is limited to fair and just compensation for the pecuniary injuries that resulted from the decedent's death. The pecuniary injuries are purely economic and are limited to loss of inherence to the distributees (calculated as lost wages), funeral expenses, and medical costs. Currently, surviving family members may not recover for emotional distress in a wrongful death case.

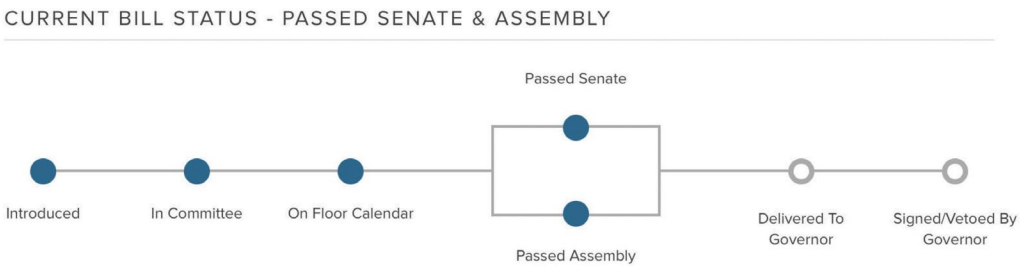
Historically, New York courts have strictly interpreted the wrongful death statute and limited the recovery in a wrongful death action to pecuniary losses, thereby preventing recovery for non- economic damages (i.e. grief, loss of affection, etc.). Similarly, the courts have strictly applied the statute to limitations those qualified as the decedent's "distributees," as EPTL §4–1.1 defines as a surviving spouse and/or blood relatives (e.g., parents, issue, brothers and sisters).

Key Changes

On January 6, 2021, a Bill was introduced and sponsored by New York State Senator Brad Hoylman (D), which sought to codify the "wish list" of thirty (30) years of attempted tort reform to New York's wrongful death statute. Key changes in this Bill include:

- Expansion of who may bring a cause of action to "close family members", which includes, but is not limited to, a spouse or domestic partner, issue, parents, grandparents, step-parents and siblings, and such qualifications will be decided by a jury;
- Extension of the statute of limitations for wrongful death from years to 3.5 years[6]; and
- Allowing an award of damages for "grief of anguish" caused by the decedent's death, "loss of love, society, protection, comfort, companionship and consortium", "loss of diminishment of inheritance", and "loss of nurture, guidance, counsel, advice, training and education".

PROCEDURAL STATUS



The Bill easily passed the Senate and Assembly. It must now be delivered to Kathy Hochul (D). She can sign or veto it. We still expect the Governor to sign it in some fashion. She has been subject to intense and constant lobbying efforts by many of her biggest donors to do so. A broad-based cohort of organizations and individuals have also expressed their informed opposition to the law. This change would put New York among the states with the longest statute of limitations for wrongful death. 0.5% of America has a 2-year-or-less statute of limitations. Only 29.5% of the nation has a statute of limitations over 2 years. In fact, the proposed 3 ½ year statute of limitations would make New York most generous in terms of statute of limitations in the entire nation.[6]

Now that the gubernatorial election is over, the GFA must be enacted in the near future or it will be subject to a "pocket veto." If the Governor does not sign the Act into law by December 31, 2022, it will be vetoed and sent back to the Legislature. The GFA as currently written applies to pending and future litigation. It is possible that the Governor will let the bill die so the Legislature can pass a prospective bill that does not apply to pending litigation and that defines "close family" rather than leaving it for a jury to decide. There is no consensus as to what the Governor will do, and thus there is at worst a 50/50% chance that she will give into to lobbyist pressure and sign it as is.

Lee Zeldin, the Governor's opponent in the election this fall made her alleged "complicity in nursing home deaths" a feature of his campaign.[7]

While the GFA has zealous proponents, the Governor also received tremendous opposition to it, citing the disastrous impact it will have on State businesses and liability insurance premiums for both public and private entities. At this time, it is anticipated that medical malpractice liability coverage could be increased by nearly 40% by the GFA. Additionally, from a practical standpoint, the GFA could cause businesses and new companies to leave New York, impacting the State's economy. Governor Hochul previously vetoed bills on the basis of their "significant negative impact" both on businesses and hospitals, which have only recently begun to recover following COVID-19. However, there is no indication that this bill be vetoed. It will likely be signed into law, albeit in a slightly altered state.

IMPACT

A) Statute of Limitation

The new Statute of Limitations for wrongful death will be 3.5 years, affording plaintiffs an additional one year and 6 months to file a claim.

- Claims and risk managers should anticipate that they will need to maintain a file for a potential wrongful death claim for an additional 1 ½ years under the current statutory scheme.
- Under the present scheme, a claim for wrongful death expires in 2 years, prior to claims for medical malpractice (2.5 years) and negligence (3 years). Under the new law, we would expect to see claims solely for wrongful death, since it will now have the longest statute of limitations at 3.5 years.
- If a plaintiff timely files a wrongful death action but misses the deadline to file a malpractice/negligence claim, then he/she cannot claim pain and suffering of the decedent from the time of the malpractice/ negligence to death. Rather, plaintiff would be limited to the damages outlined in the EPTL and GFA (i.e. pecuniary loss, funeral costs, grief of close family members).

B) Significant Expansion of Damages

The GFA significantly expands the value of wrongful death claims in New York. The question is: how much? As discussed in more detail below, we suspect wrongful death cases will be sustainable at *minimum* of $1 million or more per claimant.

The GFA allows for recovery of emotional distress damages, including grief or anguish, including any disorder caused by said grief and anguish; loss of love, society, protection, comfort, companionship, and consortium; and loss of nurture, guidance, counsel, advise, training, and education. These vague and broad terms are undefined and there are no caps on the amounts recoverable. The language of this statute suggests that "close family members" need offer no objective evidence. Rather, they merely require the jury to accept their grief to obtain compensation. Frankly, this task is easier than it sounds. Jurors will recall the grief and pain they suffered when they lost loved ones, which likely did not lead to professional help, and assume that each mother/sister/husband/grandson suffered similar grief for the loss of their decedent. It will be extremely difficult, and potentially counterproductive, to cross-examine a grieving family member. This will require extensive pretrial discovery of each "close family member."

We predict there will be high jury verdicts. The larger issue will be the sustainable limits of "grief." For that analysis, an appellate court will consider whether an award "deviates materially from what would be reasonable compensation." *Gullapa v. Key Fat Corp.*, 98 A.D.3d 650 (2nd Dept. 2012). The following are case studies providing examples of how an award based solely on GFA damages for grief or anguish could play out:

Case study #1: A Bronx couple conceived their third child and began pre-natal care with the patient's OB/GYN. Due to mismanagement of the patient's delivery, the baby passes away at age 4 days. The baby leaves behind his parents, 2 sisters, and 4 grandparents. In the past, the damages in this case would be extremely limited, estimated at approximately $250,000. However, under the GFA, we believe that each parent's grief can be sustained for at least $1 million each, the sister's grief at approximately $1 million each, and the grandparents at approximately $500,000, bringing potential estimated damages from $250,000 up to $6 million. These facts can be easily applied to general liability cases whenever a young child dies.

Case study #2: A 94-year-old patient with a history of atrial fibrillation, congestive heart failure, peripheral artery disease, dementia, recent stroke and diabetes, is admitted to a nursing home. Plaintiff alleges that the patient was permitted to suffer a sacral pressure ulcer and a fall causing a fractured hip, and eventually passed away to due sepsis seeded from an undiagnosed UTI. These events occurred over the course of a 4-week admission in the Brooklyn nursing home. The patient was survived by 3 daughters, a sister and a boyfriend who resided with her prior to death. If this case were brought in Kings County under the present law, sustainable valuation would be approximately $450,000 and settlement valuation would be approximately $250,000. However, under the GFA, if the jury finds the above to be "close family members" as well as adequate "grief", each family member can be sustained at approximately $1 million rendering this a catastrophic loss upwards of $4 million.

Case study #3: A 42-year-old construction worker sustained a fall at work in Manhattan. He is treated at the local hospital and sent home with a diagnosis of a torn ligament. He returns a week later complaining of difficulty walking. He is examined and sent home with pain medication. He subsequently dies from undiagnosed PE/DVT. At the time of his death, he is survived by his wife, his 3 school age children, 2 step-children, 1 parent, 1 grandparent and 2 sisters. Assuming plaintiff's counsel convinces a jury that he is a family man who is a significant loss to them all, we expect an appellate court would sustain at least $1 million for the wife, $1 million for each of the children, $1 million for his parent, $1 million for each sister and $500,000 for his grandparent, bringing exposure to $9.5 million, which does not even include his loss of inheritance (calculated as lost wages). This is compared to a valuation of approximately $4.5 million under the prior wrongful death law (again not considering loss of inheritance).

C) Effects on Litigation

If passed in its current form, the GFA will go into effect immediately and apply to not only future litigation, but all current pending actions where the decedent expired less than 3.5 years ago, thereby giving the GFA retroactive impact. This is arguably unconstitutional, which we would advance to the Court of Appeals as a defense. Defendants on the trial calendar will also likely be deprived of discovery pertinent to any pending claims. For these reasons, there is tremendous pressure on the Governor to insist that the GFA only apply to newly-commenced lawsuits.

Amendment of Existing Lawsuits

As for existing lawsuits, should there remain a viable Statute of Limitations under the expanded 3½ years once GFA passes, plaintiffs will likely move to amend existing complaints to add new parties, additional wrongful death claims for each of them, and include these newly available damages.

Lawsuits by Multiple Family Members & Increased Motion Practice

Once the GFA is passed, defendants could face numerous lawsuits by multiple family members. Motions to consolidate may be needed in more cases, although we will need to assess that on a case-by-case basis.

Increased Litigation Costs

Enactment of the GFA will lead to increased litigation costs and time for final disposition of lawsuits. Specifically, the expansion of individuals who can recover damages under the act will lead to more depositions and documentary discovery to investigate their claim of being a "close loved one."

Changes to Discovery

The GFA will require a rethinking of how discovery is conducted from the onset of the litigation up through the eve of trial.

1. The Bill of Particulars must include a demand for the identity of any party who either claims to be in the class of "close family member" or experiencing "grief." The Bill of Particulars must also ask for any social work, mental health, missed work, change in routine, medication or assistance required as a result of the "grief." Finally, the Bill of Particulars must demand that each member of that class set forth the basis of the claim that they are a "close family member," and particularize their "grief."

2. Thought should be given as to whether Interrogatories may be served to "close family members." In personal injury cases, a defendant may not obtain Interrogatory Responses and a deposition. Thus, the defendant is limited to a Bill of Particulars. However, since the GFA is statutory, the argument could be made that defendants are entitled to Interrogatories and the deposition of "close family members." Interrogatories are superior discovery devices to a Bill of Particulars. However, the inverse would be true and plaintiffs would likewise be permitted to demand an Interrogatory Response from defendant. Thus, caution should be deployed.

3. A demand must be made for the medical records, employment records, and mental health records of all alleged "close family members."

4. The Preliminary Conference will be crucial. There must be a deadline for plaintiff to identify "close family members" in the PC Order. The Order must require paper discovery regarding the alleged "grief" and evidence of "closeness." Likewise, there must be language that requires all "close family members" to be deposed after paper discovery regarding their "grief" is completed and before defendants' depositions start. We caution against proceeding with the PC prior to obtaining at least an initial listing of all alleged "close family members."

5. An investigator should obtain complete background checks on the "close family members," as well as a social media search prior to depositions.

6. Each alleged "close family member" must be deposed. This is crucial. Questioning should focus not only on their grief but the basis of their claim that they were "close family members." This should be done after receipt of the document discovery.

7. Defendants should not be deposed prior to the close family members. Each member may have allegations or interaction with the defendants.

8. Expert discovery should be explored depending on the claims by plaintiff. Utilization of psychiatrists/ psychologists in each case will become more commonplace.

EMPIRICAL EVIDENCE

Under certain circumstances, New York Courts have sustained jury verdicts for emotional damages. Those instances are when a mother loses a fetus and when a family member is in the "zone of danger." While "grief" and the other damages under the GFA not entirely analogous (and likely to be valued at a higher amount), the sustainable verdicts for these damages can be instructive.

A) Sustainable Verdicts for Emotional Damages in New York

To date, the highest decision sustaining an emotional damages award is $1,000,000. *See Ferreira v. Wyckoff Heights Medical Center*, 885 N.Y.S.2d 143 (2nd Dept. 2009) (Mother alleged malpractice after delivering a stillborn infant). This case is from 2009 and we expect that the Appellate Courts are thus poised to sustain even larger awards, but it is fair to assume that $1,000,000 will be upheld as to each "close family member" if it is awarded.

While there are other jury awards for emotional damages, they were seemingly not appealed or deemed sustainable. Still, they provide some insight into how juries valued emotional damages claims over the years. *See Weidemann v. Jahnke*, 2006 WL 3849196 (Otswego Cty Ct. 2006) (a jury awarded $475,000 in damages for a wrongful death claim involving a motorist who died minutes after an accident whose wife was in the "zone of danger" and alleged negligent infliction of emotional distress.); *Stark v. Semeran*, 1996 WL 935329 (Onondaga Cty Ct 1996) (medical malpractice case of 38 year-old female plaintiff who underwent a diagnostic laparoscopy resulting in the loss of an 18- week-old fetus; she did not know she was pregnant at the time of the procedure and received an award of $200,000 for emotional trauma related to the loss of her fetus.)

B) Sustainable Verdicts in Other States with No Damages Cap

Also notable, 29 out of 50 states have caps on the types of damages allowed by the GFA. We refer you to **Appendix A**, which outlines a state-by-state comparison. The caps average out to be approximately $600,000. Most of the caps are less than $500,000, with only 3 outliers allowing more than $1 million per claimant. We suggest that it should be argued that this average should be the outer limit of sustainable values in New York. However, in the absence of a cap in New York, based upon the *Ferreira* case, we believe the Appellate Courts will sustain much higher verdicts, especially where there are multiple claimants.

Appendix B is the sustainable value of similar claims in the states that do not have a cap. As you can see, the average of the sustained verdicts we located is $6.8 million. Finally, by way of comparison, we provide as **Appendix C** the relevant wrongful death statute in each state.

CONCLUSION

As mentioned in the introduction of this white paper, the GFA will increase medical malpractice and nursing home losses by 45.3%, causing premiums to skyrocket by 39.5%. Automobile insurance will increase by 6% due to a 6.9% increase in losses, and general liability premiums will jump 10.9% due to a 12.3% increase in losses. Self-insured entities will suffer a 15.3% increase in losses, and an even higher jump by hospitals and nursing homes will be seen.

The GFA will result in a profound impact on litigation and damages awards in New York State. We recommend that our clients account for these changes by:

- Considering the GFA when underwriting a risk;
- Obtaining adequate insurance, including excess and umbrella coverage up to at least $10 million;
- Considering binding "claims made policies" to cover new claims with the more robust coverage;
- Insisting on immediate and detailed analysis of the potential exposure, including potential "close family members", at the onset of litigation by defense counsel so adequate reserves are set;
- Ensuring that defense counsel are "trial ready." Plaintiff's firms will not have any fear of defense counsel who are unprepared to bring the claim to trial and will demand exorbitant settlements. Further, defense counsel who is unfamiliar with the evidence needed to refute these claims at trial will not adequately work up the case pretrial.
- Ensuring that defense counsel has a robust appellate practice. There will be a myriad of issues to be determined by the appellate courts, including the constitutionality of any amendments, scope of discovery, role of expert evidence, trial evidence and sustainable values.

With respect to the pending legislation, clients are urged to contact their local Senator and Assemblyperson to point out the flaws in this legislation, including: 1) the unconstitutional retroactive application; 2) the lack of damages caps; 3) the broad definitions of a "close family member"; and 4) the arbitrary measure of damages flowing from a loved one's "grief".

To provide comments and opinions regarding the bill in its current form, please visit: https://www.nysenate.gov/legislation. You can "search bills" and input **Senate Bill S74-A** or **Assembly Bill A.6770**, which will bring you to a survey asking for the public's input.

References on page 40

APPENDIX A
MEDICAL MALPRACTICE DAMAGES CAPS BY STATE

STATE	NON-ECONOMIC DAMAGE CAPS	ECONOMIC DAMAGES	STATUTE
Alabama	Ruled unconstitutional by state court	Ruled unconstitutional by state court	Ala. Code § 6-5- 544(b): Alabama Supreme Court has declared the limitation on damages within the statute unconstitutional. Moore v. Mobile Infirmary Association, 592 So.2d 156 (Ala.1991); Mobile Infirmary Med. Ctr. v. Hodgen, 884 So. 2d 801 (Ala. 2003) N/A
Alaska	Non-economic: including wrongful death or a disability considered more than 70% disabling: $400,000	None	Alaska Statutes 09.17.010
Arizona	None	None	N/A
Arkansas	None	None	N/A
California	$250,000	None	California Code of Civil Procedure sections 340.4 and 340.5
Colorado	$300,000	$1,000,000 total damages	Colorado Revised Statutes 13-80-102.5
Connecticut	None	None	N/A
Delaware	None	None	N/A
District of Columbia	None	None	N/A
Florida	Ruled unconstitutional by state courts	Ruled unconstitutional by state courts	*North Broward Hospital District vs. Susan Kalitan* (2022)
Georgia	Ruled unconstitutional by state courts	Ruled unconstitutional by state courts	*Nestlehutt v. Atlanta Oculoplastic Surgery*, 691 S.E.2d 218 (Ga. 2010)
Hawaii	$375,000 with limited exceptions	None	Hawaii Revised Statutes 663-8.7
Idaho	$250,000	None	Idaho Code section 6-1603
Illinois	Ruled unconstitutional by state courts	Ruled unconstitutional by state courts	I - 237 Ill. 2d 217, 341 Ill. Dec. 381, 930 N.E.2d 895 (2010)
Indiana	$1,250,000 combined for any act of malpractice	$1,250,000 combined for any act of malpractice	Indiana Code section 34-18-14-3
Iowa	$250,000	None	Iowa Code §147.136A
Kansas	Ruled unconstitutional by state courts	None	Kansas Statute 60- 19a02 held unconstitutional: Hilburn v. Enerpipe Ltd., 309 Kan. 1127 (2019)
Kentucky	None	None	N/A

STATE	NON-ECONOMIC DAMAGE CAPS	ECONOMIC DAMAGES	STATUTE
Louisiana	$500,000 combined exclusive of future medical expenses.	$500,000 combined exclusive of future medical expenses. Health care providers liable for only $100,000 with the rest paid by compensation fund	Louisiana Revised Statutes section 40:1231.2
Maine	$750,000	None	Maine Revised Statutes 18-A Section 2-807(2).
Maryland	$845,000	None	Maryland Code 11-108
Massachusetts	$500,000	None	Massachusetts Code 231 § 60H.
Michigan	$489,000 unless exception for total loss of bodily functions, then; $832,000. Adjusts annually for inflation	None	Michigan Judicature Act 236 of 1961
Minnesota	None	None	N/A
Mississippi	$500,000	None	Mississippi Code Section 11-1-60
Missouri	$450,000 for non-catastrophic; $787,000 for catastrophic injuries	None	Missouri Statute 538.210.8
Montana	$250,000	None	Montana Code Annotated section 25-9-211
Nebraska	$2,250,000 combined non-economic and economic damages.	$2,250,000 combined non-economic and economic damages.	Nebraska Revised Statutes Section 44-2825
Nevada	$350,000	None	Nevada Revised Statutes Section 41A.035
New Hampshire	None; Ruled unconstitutional by state courts	None; Ruled unconstitutional by state courts	Brannigan v. Usitalo 134 N.H. 50 (1991)
New Jersey	None; only punitive damages	None; only punitive damages	Punitive damages capped at $350,000 or five times compensatory damages per N.J.S.A 2A 15-5.14
New Mexico	$600,000; excludes punitive damages and medical treatment.	$600,000 excludes punitive damages and medical treatment.	Affirmed by Siebert v. Okun in 2021
New York	None	None	N/A
North Carolina	$500,000	None	North Carolina General Statutes 90-21.19
North Dakota	$500,000	N/A	North Dakota Statutes 32-42-02
Ohio	$500,000 per plaintiff; $1,000,000 per occurrence	None	Ohio Revised Code section 2323.43

STATE	NON-ECONOMIC DAMAGE CAPS	ECONOMIC DAMAGES	STATUTE
Oklahoma	Declared unconstitutional by State Court	None	Beason v. I.E. Miller Services, Inc 441 P.3d 1107 (2019)
Oregon	Declared unconstitutional by State Court	None	Vasquez v. Double Press Mfg, 2017; Busch v. McInnis Waste, 2020)
Pennsylvania	None	None	N/A
Rhode Island	None	None	N/A
South Carolina	$350,000 for each institution, not to exceed $1,050,000 per claimant.	None	South Carolina Code of Laws section 21-3-11
South Dakota	$500,000	None	South Dakota Code of Laws section 21- 3-11
Tennessee	$750,000 for all plaintiffs combined	None	Tennessee Code Annotated section 29-39-102
Texas	$250,000 per claimant; if more than one institution, capped at $500,000	None	Texas Civil Practice and Remedies Code section 74.301.
Utah	$450,000	None	Utah Code section 78B-3-410
Vermont	None	None	N/A
Virginia	Total damages not to exceed $2,500,000 in combined economic and non-economic loss	Total damages not to exceed $2,500,000 in combined economic and non-economic loss	Virginia Code Section 8.01-581-15
Washington	Ruled unconstitutional by state courts	Ruled unconstitutional by state courts	Sofie v. Fireboard Corp, 1989
West Virginia	$250,0000 per occurrence regardless of number of plaintiffs or defendants.	None	West Virginia Code section 55-7B-8
Wisconsin	$750,000	None	Wisconsin Statutes section 893.55
Wyoming	Prohibited by state constitution	Prohibited by state constitution	WY Constitution Article 10 Section 4

APPENDIX B
SUSTAINABLE VERDICTS FOR EMOTIONAL DAMAGES IN STATES WITHOUT CAPS

STATE	HIGHEST VERDICT	SUSTAINED?
Alabama	$40,250,000 on wrongful death claim ($10 mil for spouse, $17 mil or minor child, $13.25 mil punitive) from drunk driving accident. *Rush v. Kendrick*, 2013 WL 2390735 (Ala.Cir.Ct.2013)	Subsequently settled.
Arizona	$40,000,000 in traffic accident, which was later remanded due to mistake in jury instructions on wrongful death. Rincon v. Rumsey, No. 2 CA-CV 2010-0150, 2011 WL	Arizona
Arkansas	No	Reported
Connecticut	No	Reported
Delaware	$1.5 million to spouse in asbestos case. Galliher v. American Optical Corp., 2012 WL 5942439 (Del. Sup.)	Appealed, but remanded due to error in jury instructions.
Illinois	$7,217,656 in asbestos case awarded to wife and 2 children. O'Reilly v. U.S. Steel Corp., et al, JVR No. 2207070007 (Cir. Ct Ill. 2022).	Reduced to $3,753,181 for comparative fault and calculation error on the verdict sheet. O'Reilly v. Fisher Controls Intern. LLC, No. 2020-L-001796, 2022 WL 3024147, at *1 (Ill.Cir.Ct. June 01, 2022).
Kentucky	$7.5 million awarded to 2 minor children and spouse for wrongful death involving a truck accident. J. Short v. Marvin Keller Trucking Inc., JVR No. 2203070017 (E.D.	Not appealed.
Minnesota	$500,000 for failure to diagnose bowel obstructions. Cafferty v. Millie Lacs Health System, JVR No. 1912110063 (Minn. Dist. Ct. 2019).	Not appealed.
New Jersey	$300,000 for failure to diagnose cancer awarded to husband and two adult children. Cox v. Tenner, JVR No. 2204200013 (NJ Sup Ct. 2022).	Not appealed.
Ohio	$800,000 to spouse and three adult children for malpractice involving a geriatric patient. Michaels v. Ghoubrial, JVR No. 2204270009 (Ohio 2022).	Not appealed.
Pennsylvania	$950,000 awarded to wife and adult sons for truck accident. Renee v. Shields, JVR No. 2207070030 (Penn. 2022).	Not appealed.
Rhode Island	No reported decisions found detailing economic damages alone.	N/A

STATE	HIGHEST VERDICT	SUSTAINED?
Vermont	No	Reported
Virginia	$ 6.5 million	Circuit Court upheld emotional damages for $6.5 Million based on wrongful death stemming from a delay in woman's incurable breast cancer diagnosis: Cox v. Gamache Cox 2009 WL 1912388 (Wash. Super. 2008).
Washington	$11 million	Superior Court upheld emotional damages for $11 Million based on wrongful death stemming from child who fell in and drowned in neighbor's yard. *Tobin v. State of Wash.* 2008 WL 5100879 (Wash. Super.)
Wyoming	No reported decisions found detailing economic damages alone.	

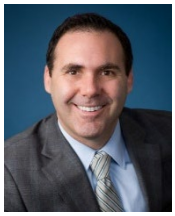
APPENDIX C
WRONGFUL DEATH STATUTES BY STATE

STATE	WHO CAN BRING A WRONGFUL DEATH LAWSUIT?	STATE STATUTES ON WRONGFUL DEATH
Alabama	Personal representative for decedent's estate	Alabama Wrongful Death Act, Ala. Code §6-5-410 Alabama Probate Code, Ala. Code §43- 8-40 *et. seq.*
Alaska	Decedent's personal representative	Alaska Statute, AS 09.55.580
Arizona	Surviving spouse, child, parent, or personal representative of deceased person	Arizona Wrongful Death Act, AZ REV ST §§12-611, 12-612, 12-613
Arkansas	Decedent's estate as well as surviving spouse, children, parents or siblings	Arkansas Code §12-62- 102
California	Surviving spouse, domestic partner, children, stepchildren, and grandchildren	Cal. Code of Civ. Proc. §§377.60, 377.61
Colorado	First year after death: surviving spouse only Second year: surviving children can also file	Colorado Wrongful Death Act
Connecticut	Executor or administrator of the decedent's estate	Con. Gen. Stat. §52- 555
Delaware	Spouse, parent, child or sibling of decedent or a person related to decedent by blood or marriage	Delaware Code Title 10 §3724
Washington D.C.	Decedent's personal representative must file on behalf of surviving spouse, if not, on behalf of children, parents or siblings of decedent	District of Columbia Code §§16-2701, 16-2703

STATE	WHO CAN BRING A WRONGFUL DEATH LAWSUIT?	STATE STATUTES ON WRONGFUL DEATH
Washington D.C.	Decedent's personal representative must file on behalf of surviving spouse, if not, on behalf of children, parents or siblings of decedent	District of Columbia Code §§16-2701, 16-2703
Florida	Personal representative has duty to bring action on behalf of surviving spouse, minor children, and parents	Florida Wrongful Death Act
Georgia	Surviving spouse must bring claim on behalf of decedent and any surviving children; if none, claim can be brought by surviving parents or personal representative	Georgia Code Title 51. Torts § 51-4-2
Hawaii	Decedent's personal representative, surviving spouse, "reciprocal beneficiary," surviving children, parent, or anyone who was financially dependent on the decedent	Hawaii Revised Statutes Division 4. Courts and Judicial Proceedings § 663-3
Idaho	Decedent's personal representative, heirs, spouse, children, stepchildren, parents, or any other dependent blood relatives	Idaho Statutes Title 5 § 5-311
Illinois	Decedent's personal representative	Illinois Wrongful Death Act
Indiana	Decedent's personal representative	Indiana Code §34-23- 1-1
Iowa	Administrator of the decedent's estate, spouse and surviving minor children, adult children, or parents of the decedent	Iowa Code Title XV. § 633.336
Kansas	Brought by decedent's estate for the benefit of the heirs at law	Kansas Statutes Chapter 60 § 60-1901
Kentucky	Decedent's personal representative	Kentucky Revised Statutes Title XXXVI §411.130
Louisiana	Surviving spouse or children, parents or siblings of the decedent	Louisiana Civil Code Tit. V, Art. 2315.2
Maine	Decedent's personal representative	Maine Revised Statutes Title 18-A § 2-804
Maryland	Primary beneficiaries can file on behalf of themselves; secondary beneficiaries can file on behalf of the estate	Maryland Code, Courts and Judicial Proceedings § 3-904
Massachusetts	Executor or administrator of estate	Massachusetts General Laws Part III Ch. 229, § 2
Michigan	Decedent's personal representative	Michigan Compiled Laws, Chapter 600 § 600.2922
Minnesota	Surviving spouse and children, parents, grandparents, or siblings of decedent	Minnesota Statutes §573.02
Mississippi	Decedent's personal representative, surviving spouse, parent, child or siblings	Mississippi Code Title 11 §11-7-13
Missouri	Surviving spouse, children, or lineal descendants; if no such person, siblings of the decedent or their descendants	Missouri Revised Statutes Title XXXVI §537.080
Montana	Decedent's personal representative	Montana Title 27 §27- 1-513
Nebraska	Decedent's personal representative	Nebraska Revised Statutes Chapter 30§ 30-809

STATE	WHO CAN BRING A WRONGFUL DEATH LAWSUIT?	STATE STATUTES ON WRONGFUL DEATH
Nevada	Decedent's personal representative, surviving spouse, children or parents	Nevada Revised Statutes Title 3 §41.085
New Hampshire	Any person interested in the estate of the deceased	New Hampshire Rev. Statutes Title LVI §556:12
New Jersey	Decedent's personal representative	New Jersey Wrongful Death Act
New Mexico	Decedent's personal representative	New Mexico Statutes §41-2-1
New York	Decedent's personal representative	New York Consolidated Laws, Estates, Powers and Trusts Law EPT § 5- 4.1, *see also* Grieving Families Act
North Carolina	Decedent's personal representative	North Carolina General Statutes §28A-18-2
North Dakota	Surviving spouse, children, parent, grandparent or decedent's personal representative	North Dakota Century Code §32-21-01
Ohio	Decedent's personal representative	Ohio Revised Code Title XXI §2125.01
Oklahoma	Decedent's personal representative	Oklahoma Statutes §12-1053
Oregon	Decedent's personal representative	Oregon Revised Statutes §30.020
Pennsylvania	Decedent's personal representative	Pennsylvania Wrongful Death Act
Rhode Island	Executor or administrator of the estate	Rhode Island General Laws §10-7-1
South Carolina	Executor or administrator of the estate	South Carolina Code of Laws §15-51-10
South Dakota	Decedent's personal representative	South Dakota Codified Laws §21-5-5
Tennessee	Initial right to file belongs to surviving spouse. If no spouse, in order: surviving children or next of kin, personal representative, surviving parents, administrator of the estate	Tennessee Code §20-5- 106
Texas	Surviving spouse, children and parents of the decedent individually, or together	Texas CIV PRAC & REM Code §71.00
Utah	Decedent's heirs or personal representative	Utah Code §78B-3-106
Vermont	Decedent's personal representative	Vermont Statutes Title 14 §1491
Virginia	one or more statutory beneficiary, including the decedent's surviving spouse, children, grandchildren, parents, siblings, other relatives who lived with the decedent, or anyone else entitled to inherit from the decedent's estate	Virginia Code §8.01-50
Washington	Decedent's personal representative, surviving spouse, or children	Washington Revised Code §4.20.010
West Virginia	Decedent's personal representative	West Virginia Code §55-7-5
Wisconsin	decedent's personal representative or a surviving spouse, children, or parent	Wisconsin Statutes §895.04
Wyoming	Decedent's personal representative	Wyoming Statutes §1- 38-101

About the Authors



Dylan Braverman is a Partner and Co-Chair of the Firm's COVID-19 litigation team. The COVID-19 litigation team is a nationally recognized leader in defending against COVID-19 claims. Dylan and his team are lead counsel defending Municipalities, Health Systems, Nursing Homes and other professionals against COVID-19 claims throughout New York and the nation.

Dylan is also the Co-Chair of the Firm's Nursing Home practice group. This subspecialty aggressively defends nursing homes in the New York metropolitan area.

For over 20-years, Dylan has specialized in complex civil litigation, commercial litigation, insurance coverage and healthcare services. He has been awarded Super Lawyer designation since 2018, representing the top 5% of the attorneys in New York City.

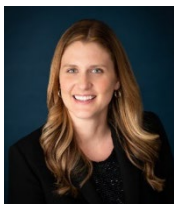
He is a Board Member and former-President of the Associate of Healthcare Risk Managers of New York ("AHRMNY"). He is still intimately involved with his adopted home in Harlem, New York where he lived for almost 25-years. He currently lives in Westchester with his family, where he is a Division Coordinator and Coach of the local American Youth Soccer Organization. Dylan has traveled to every continent and visited dozens of countries.



Megan Lawless is Chair of VBPNP's Appellate Practice Group and leads the firm's appellate efforts in all COVID-19 legal matters, including the briefing of first impression legal issues before the United States Court of Appeals for the Second Circuit and New York's Appellate Divisions. Megan has also won significant dispositive motions at the trial level in New York.

Prior to joining VBPNP, Megan managed a nationwide-network of outside counsel at WorldCom, Inc. in varied commercial litigation matters. Megan also practiced products liability litigation at Patterson Belknap Webb & Tyler LLP in New York, and commercial and products liability litigation at Troutman Pepper in Philadelphia.

Megan earned her Juris Doctor from Pennsylvania State University, The Dickinson School of Law in 1996, where she graduated *Cum Laude*, and was a member of the Dickinson Law Review, the Appellate Moot Court Board and the Woolsack Honor Society. Megan was also a College Honors Scholar and graduated *Magna Cum Laude* from Mt. St. Mary's University, where she earned a B.A. in History. Megan is admitted to practice law in the states of New York, New Jersey, and Pennsylvania.



Nicole M. Varisco is a partner in the firm's Westchester office. Nicole litigates complex, high exposure cases in federal courts of New York and New Jersey. She is duly admitted in both jurisdictions and obtained her law degree *cum laude* from Pace University School of Law. She obtained her undergraduate degree from St. Thomas Aquinas College in Rockland County, New York Prior to joining this firm, Ms. Varisco worked at l national law firms as litigation counsel.

Nicole is a member of the Westchester County Bar Association, where she serves as chair of the Law Practice Management Committee, American Society for Healthcare Risk Management (ASHRM) and the New Jersey Defense Association. She is frequently a speaker for legal education events, and her recent speaking engagements are listed below. In her spare time, Ms. Varisco volunteers as a wish granter for the Hudson Valley Chapter of Make A Wish, and is an avid hiker.

Call for Speakers!

The Association for Healthcare Risk Management of New York, Inc. (AHRMNY) is seeking speakers for our upcoming 2023 Annual Conference (exact date TBD).

Topics submitted should relate to risk management, patient safety, insurance, quality improvement, medicine, healthcare law, government regulations, as well as notices of improvement and other relevant information of interest to risk managers.

Submit suggested topics and speakers here

If you have any questions or need additional information, please reach out to AHRMNY's Education Committee at ahrmny@gmail.com.

Thank you!

Advertise Your Business in the Risk Management Journal

Reach over 300+ Risk Management and Patient Safety Professionals while also supporting educational programs.

Cost of Advertisement: $500

Includes:

- Design and placement of advertisement in one (1) issue of the Risk Management Journal
- Link to your company's website

Complete Advertisement Application Here

MEMBER SPOTLIGHT

Join us in congratulating the following AHRMNY members for volunteering to share their achievements featured in this edition's MEMBER Spotlight

David L. Feldman, MD, MBA, CPE, FAAPL, FACS - Healthcare Risk Advisors and TDC Group



David Feldman is the Chief Medical Officer for The Doctors Company and TDC Group, and Senior Vice President at Healthcare Risk Advisors. He recently presented work he and his colleagues are doing with their client hospitals at the ASHRM Annual Conference in Boston. The topic was "Shouldering the Responsibility: Implementation of a Collaborative Shoulder Dystocia Initiative." Dr. Feldman recently also published "Amplify a Culture of Safety in Your Medical Practice" in *Medical Economics*. The article discusses the four principles of a safety culture: mutual respect, teamwork, human factors engineering, and just culture. In addition, he hosts a podcast series on these four principles, interviewing leaders with deep experience in organizational change, and hearing their stories from the trenches. Dr. Feldman leads TDC Group's education efforts and is the primary spokesperson for trends and issues on patient safety and risk management. Through his leadership at HRA, TDC Group provides resources and a collaborative environment designed to minimize claims and lower premiums for HRA's and The Doctors Company's clients by preventing patient harm, enhancing teamwork and communication, and improving documentation.

Andrea Patram, MPH - Healthcare Risk Advisors



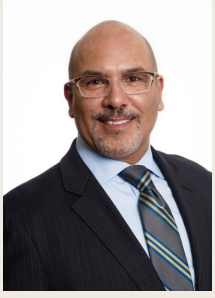
Andrea Patram is Manager of the Risk Management Department at Healthcare Risk Advisors, part of TDC Group, which provides insurance and risk management services, including reducing liability and improving patient outcomes, for New York healthcare professionals. Ms. Patram manages various obstetrics and emergency medicine quality and patient safety initiatives. She coordinates risk management services to clinicians by providing resources to improve documentation and enhance communication with patients and other providers. With over 15 years of risk management and patient safety experience, Ms. Patram is known for maximizing operational excellence by working closely with clinical leadership to provide optimal outcomes on best practice topics relevant to reducing malpractice risk. She recently presented with colleagues at the 2022 ASHRM Annual Conference in Boston on "Shouldering the Responsibility: Implementation of a Collaborative Shoulder Dystocia Initiative." Ms. Patram is a member of national organization ASHRM. She is also a member of AHRMNY and serves on its Public Relations Committee.

Shelise Valentine, RNC, MSN, C-EFM, CPPS, CPHRM - Healthcare Risk Advisors



Shelise Valentine is the Director of Nursing at Healthcare Risk Advisors, part of TDC Group. In this role, Ms. Valentine chairs nursing, co-chairs obstetric and simulation initiatives, and directs risk management and obstetric education for insured hospital clients to improve patient safety and reduce malpractice risk. She has certifications in external fetal monitoring, patient safety, and healthcare risk management. Ms. Valentine has lectured and presented locally and nationally on patient safety, obstetrical safety, and risk management initiatives. She is active in a variety of organizations, including the Association of Women's Health, Obstetric and Neonatal Nurses, the American Society for Healthcare Risk Management, the Institute for Healthcare Improvement's Better Maternal Outcomes Rapid Improvement Network, and MomsRising. She recently presented "Shouldering the Responsibility: Implementation of a Collaborative Shoulder Dystocia Initiative" with her colleagues at the 2022 ASHRM Annual Conference.

Jose L. Guzman, Jr., MS, BS, RN, CPHRM, DFASHRM - Hudson Insurance Group



Jose Guzman was recently elected to the American Society for Health Care Risk Management's (ASHRM) Advisory Board for the 2023-2025 Term. The ASHRM Advisory Board is elected by membership-at-large to set their strategic direction and ensure plans are implemented to advance the group's vision and mission. In addition to being elected to the Advisory Board, since 2003, Jose has served on various ASHRM committees as a member and/or Chair, and had previously served on the organization's Nominating Committee following his election in 2019. Mr. Guzman currently serves as the Vice President and Managing Director, Healthcare Risk Management for Hudson Insurance Company. He is also Vice President of Napa River Insurance Services, a TPA provider. Jose holds the CPHRM and DFASHRM distinctions.

MEMBER SPOTLIGHT

Christopher Allman, JD, CPHRM, DFASHRM - Medically Home



Christopher Allman is the Director of Compliance & Privacy for Medically Home, a Boston-based national hospital at home provider. Medically Home contracts with hospitals and health systems to provide acute-level hospital care to patients' in their own homes. Christopher recently presented "Case Law Update" as a keynote speaker at the ASHRM Annual Conference in Boston. The annual presentation of legal cases pertinent to healthcare risk professionals at the ASHRM Annual Conference is a summary review of Chris's "Case Law Update" article which appears in each quarterly edition of the ASHRM Journal. Chris is also an Advisory Board member of ASHRM.

Bonnie Boone - Insurance Broker / Risk Transfer Specialist



Bonnie Boone was recently awarded the 2022 Excellence in Diversity Award from The PLUS Foundation. This award was established in 2021 to recognize a member from the insurance industry who embodies the foundation mission to "support tomorrow's diverse professional liability workforce" through their actions to advance diversity, equity, and inclusion in the industry.

Bonnie has over 39 years of experience in the insurance industry as a broker and underwriter working with some of the largest insurance companies (Gallagher, Marsh, Alliant Insurance, and Willis) and placed reinsurance for some of the largest captive programs in the country. Bonnie has developed strategy and placed professional liability and other casualty lines for a broad range of large clients both in New York and Chicago. Bonnie is a consultant with JP West, Inc. in New York.

Josh Hyatt, DHS, MBE, MHL, DFASHRM, CPHRM, CPPS, HCE-C - Coverys



Dr. Josh Hyatt is a Manager in the Risk Management and Analytics department at Coverys and an adjunct professor at the Massachusetts College of Pharmacy and Health Science. He graduated from Harvard Medical School with a Masters in Bioethics and received Doctor of Health Science and Masters of Health Law degrees at Nova Southeastern University. He has worked in health care risk management and bioethics for nearly thirty years in a variety of clinical and regulatory settings. His professional and academic interests are in the relationships between healthcare risk management/patient safety and bioethics, moral distress, and LGBT health. He has published in several peer-reviewed journals and is frequent presenter at national conferences. Currently, he is the Faculty Lead for the CPHRM Preparatory course for ASHRM and a member of the ASHRM Journal Editorial Board.

Dawn Pignatelli, Esq. - Bartlett, LLP
Mike Midgley, RN, JD, CPHRM, DFASHRM - Munich Re Specialty Insurance





Current AHRMNY Board Members, Dawn Pignatelli and Mike Midgley, presented a dynamic session at the recent ASHRM Annual Conference in Boston and the subsequent ASHRM Virtual Conference on information blocking regulatory mandates of the 21st Century Cures Act and associated challenges and opportunities with electronic medical record documentation and communication methods with patients, other providers, etc. Attendees were provided with an overview of the obligations under the 21st Century Cures Act information blocking rule, as well as the associated risks, liability and other significant factors related to clear and concise note writing in the electronic medical record. Attendees learned about strategies for training and education on electronic medical record documentation and management of patient access to electronic medical records as well as systems to best communicate between patient and provider.

Dawn Pignatelli is a senior associate at Bartlett LLP in the firm's litigation practice group. Her areas of practice include the defense of long-term care and assisted living facilities, as well as home-care and hospice services, and physicians and hospitals in medical malpractice cases.

Mike Midgley RN, JD, MPH, CPHRM, DFASHRM is Head of Loss Control for Munich Re Specialty Insurance and on faculty at Loyola Law School where he teaches leadership and strategic planning. He also serves as faculty for the American Society for Health Care Risk Management (ASHRM).

Fourth Department Holds Repeal of EDTPA is Prospective, Not Retroactive, Impacting Currently Pending COVID-19 Nursing Home Litigation

By Bindu Nair

On October 7, 2022, the Appellate Division, Fourth Judicial Department concluded that the statute repealing New York's Emergency or Disaster Treatment Protection Act (the EDTPA) is to be given ***prospective*** application and not retroactive application, as has been hotly contested by plaintiffs' firms in the midst of a recent glut of nursing home litigation cases. This will significantly impact those COVID-19 litigation claims being brought against nursing homes recently in the Empire State by plaintiffs arguing that the repeal of EDTPA was meant to be retroactive, despite not having any clear indication in the legislative history of the repeal.

Background

In April 2020, then-Governor Cuomo signed executive orders declaring a state of emergency in New York. Among other things, these orders provided immunity for healthcare workers from civil liability – except in cases of gross negligence – for injury or death alleged to have been sustained directly as a result of providing medical services in support of the state's response to the COVID-19 outbreak. (*See* Executive Order [A. Cuomo] No. 202.10 [9 NYCRR 8.202.21]). Shortly thereafter, the legislature enacted the EDPTA, which provided temporary immunity to healthcare and long-term care facilities and healthcare professionals from claims related to the care of individuals with COVID-19. (*See* NY PHL former §§ 3080-3082). This immunity was in effect retroactively from March 7, 2020 through the expiration of New York's state of emergency. Immunity under the statute was limited, however, and did not apply to damages or injuries that were caused due to willful or intentional criminal misconduct, recklessness, or gross negligence.

This exemption applied if a) the services were arranged for or provided pursuant to a COVID-19 emergency rule or otherwise in accordance with applicable law; b) the act or omission was impacted by decisions or activities that were in response to or as a result of the COVID-19 outbreak and in support of the state's directives; and c) the services were arranged or provided in good faith. (*See* PHL former § 3082[1]).

In August 2020, changes to the immunity statute included the removal of various immunity protections, including those protections related to "arranging for" healthcare services and narrowing the immunity to apply specifically to the assessment or care of an individual as it relates to COVID-19.

Repeal

On April 7, 2021, the Governor signed legislation that fully repealed Art. 30 of the Public Health Law, the EDTPA "with the intent of holding health care facilities, administrators, and executives accountable for harm and damages incurred." There was no reference on the face of the bill as to whether the repeal was meant to apply retroactively and merely stated that this "act shall take effect immediately". (See A.03397/S.5177; L 2021, ch 96, §§ 1-2). Since the repeal, plaintiffs' firms have filed hundreds of nursing home lawsuits alleging, among other things, negligence related to COVID-19 going back to the beginning of the pandemic, when the EDTPA was in place. These allegations include but are not limited to: failure to enforce social distancing; failure to ensure all residents wear face coverings; failure to ensure appropriate staffing levels; failure to timely restrict all visitors; failure to screen COVID-19 symptoms resulting in the exposure and spread of COVID-19, resulting in deprivation of dignity, pain and suffering, and, in some cases, death. In many of these cases, the defendants have moved to dismiss based on this immunity. Others have moved for removal to federal court, but the federal district courts have been inconsistent on this point, with the Eastern District remanding these cases back to state courts.

Ruth v. Elderwood at Amherst

In a recent Erie County case, *Ruth v. Elderwood at Amherst*, defendants similarly moved to dismiss based on immunity and the lower court granted the motion. The plaintiff appealed, and the Fourth Department affirmed finding that the lower court properly determined that the defendants were entitled to immunity conferred by the EDTPA. 2022 NY Slip Op 05637 (App. Div.)

The Appellate Division found that a review of the legislative floor debates supported the conclusion that the legislature intended the repeal to apply prospectively only, rather than retroactively. The court specifically cited concerns from Assembly members that retroactive application of the repeal would expose frontline healthcare workers to liability for treatment they provided at the beginning of the pandemic, when far less

was known about how to provide appropriate treatment for the novel virus and workers were providing care under extraordinary circumstances. (*See* NY Assembly Debate on Assembly Bill A3397, Mar. 4, 2021).

The court further found that nothing in the repeal contained an express statement requiring retroactive application, and that the indication of immediacy in application of the repeal had no bearing on whether the repeal was meant to apply retroactively.

Impact

It is unclear whether the plaintiff in the *Ruth* matter will file an appeal to the state's highest court, the New York Court of Appeals, or whether the court will grant review. In the absence of any other decisions or caselaw on this issue, the Fourth Department decision shall serve as binding authority as to all other Departments. Therefore, these cases that fall under when EDTPA was enacted have a good defense for dismissal and should move under this precedent.

About the Author



Bindu Nair is a partner in the New York office of Lewis Brisbois and a member of the General Liability, Healthcare, and Medical Malpractice practices. Ms. Nair has extensive experience representing renowned medical institutions, long-term care facilities, outpatient medical facilities, and nursing homes, as well as their physicians and other medical practitioners in medical malpractice cases.



GOLD SPONSOR - $5,000

- Sponsor logo featured on AHRMNY website, program flyer, and displays at event venue
- Sponsor acknowledged on all event marketing and announcements
- Three (3) complimentary tickets to sponsored event
- Sponsor may distribute literature or swag at the venue
- Special acknowledgement in the Risk Management Journal
- Honarary acknowledgement during sponsored event

SILVER SPONSOR - $3,000

- Sponsor logo featured on AHRMNY website, program flyer, and displays at event venue
- Sponsor acknowledged on all marketing and announcements about event
- Two (2) complimentary tickets to sponsored event
- Special acknowledgement in the Risk Management Journal
- Honarary acknowledgement during sponsored event

BRONZE SPONSOR - $1,000

- Sponsor logo featured on AHRMNY website, program flyer, and displays at event venue
- Sponsor acknowledged on all marketing and announcements about event
- One (1) complimentary tickets to sponsored event
- Special acknowledgement in the Risk Management Journal
- Honarary acknowledgement during sponsored event



Documents Protected from Discovery in Nursing Home Cases

By Mario Giannettino, Ken Fox, Samantha Quinn, and Steph Campbell

New York State is one of the most challenging venues in the country for long-term care litigation. Of course, the notion that subpar care is rendered in skilled nursing and rehabilitation facilities is not new; Public Health Law §2801-d was enacted to address abuses in such institutions. Indeed, New York State Public Health Law §2801-d permits class actions. However, using the class action mechanism against facilities is not a favorable development for these institutions. The following article will discuss several of these actual cases, including application of the class action standard by the courts and the real risks facilities face in being forced to defend such claims. It will also discuss issues regarding discovery of privileged information, insurance considerations unique to class actions, and who should bear the costs of such cases.

Class actions can yield several benefits, including economizing litigation and incentivizing plaintiffs to pursue socially important lawsuits. Where multiple people suffer a common injury, which individually might not be worth pursuing, class action provides a unique vehicle to provide a recourse to members of the group. At the same time, however, class actions can subject defendants to costly or abusive litigation, particularly when plaintiffs engage in extensive precertification discovery.

Recently, a new trend appears to be emerging which has the potential to threaten the viability of skilled nursing and long-term care facilities in New York – nursing home class action suits. Typically, these cases claim "inadequate staffing" as the reason for myriad injuries, in an attempt to define a class, and the cases are purportedly seeking to elicit "nursing home reform" through nursing home abuse class action lawsuits. Plaintiffs' attorneys pursing such claims paint a picture of those running nursing homes as unscrupulous mercenaries with little regard for their residents' health and safety and invite concerned friends and family to stay vigilant for signs of "elder abuse and neglect."

As will be detailed further below, despite the fact that New York State Public Health Law §2801-d permits class actions, they are rarely appropriate in the context of nursing home negligence claims. It is difficult to envision a circumstance where a claim of inadequate nursing staffing was the single causative factor of injury to multiple residents. The necessity for particularized consideration of liability and damages for each resident in a purported class action should preclude the finding of common questions of law and fact required to satisfy the statutory criteria for this type of suit.

Legal Standard

A number of criteria must be met in order to satisfy the statutory requirements for a class action set forth in the Civil Practice Law and Rules (CPLR). CPLR §901(a) provides five prerequisites to class certification.

1. The class is so numerous that joinder of all the members . . . is impracticable;
2. There are questions of law or fact common to the class which predominate over any questions affecting only individual members;
3. The claims or defenses of the representative parties are typical of the claims or defenses of the class;
4. The representative parties will fairly and adequately protect the interests of the class; and
5. A class action is superior to other available methods for the fair and efficient adjudication of the controversy.

A class action may only be maintained if the five prerequisite factors above have been satisfied. If the court so finds, then discretionary factors under CPLR §902 must be considered to determine if they weigh in favor of certification of the class. Determination of whether a lawsuit qualifies as a class action rests within the sound discretion of the trial court, and the court's inquiry into the merits of class certification "is limited to a determination as to whether on the surface, there appears to be a cause of action which is not a sham." Super Glue Corp. v. Avis Rent A Car Sys., 132 A.D.2d 604, 607 (2nd Dept. 1987).

Nursing Home Class Action Suits

In *Olmann v. Spring Creek,*[1] plaintiff brought a putative class action on behalf of all residents of defendant's facility on the basis that they were harmed by poor staffing levels. Plaintiff's "proof" of their claims was the facility's staffing rating from Nursing Home Compare with ancillary affidavits attesting that residents were likely harmed from the staffing levels. Plaintiff also sought pre-Certification discovery seeking nearly every conceivable document from the facility, including staffing documents, personnel files, financial information and even more egregious, *the charts of every resident of the facility.* Incredibly, the records sought covered, at minimum, a six-year period.

The lower court denied plaintiff's motion for certification, correctly deciding that plaintiff could not meet the commonality and superiority requirements. Plaintiff appealed the decision and favorably, the lower court's decision was affirmed.

The Appellate Division was exacting in its scrutiny of plaintiff's claim. They held that questions of law or fact did not predominate over questions involving members of the proposed class as to causation and that the plaintiff failed to establish that a class action was superior to other available methods for the fair and efficient adjudication of the controversy.

Gibbs v. Kings Harbor[2] is another nursing home class action case wherein plaintiffs allege injuries to the "class" as a result of inadequate staffing. The Supreme Court correctly denied plaintiffs' original motion for class certification, holding that plaintiffs were unable to satisfy CPLR §901 and §902. Unfortunately, however, when the decision was appealed, the First Department allowed for pre-certification discovery and the opportunity for plaintiffs to renew their motion for class certification. Notably one of the named plaintiffs is alleged to have sustained Salmonella poisoning due to understaffing and the other named plaintiff's injuries are unspecified.

Plaintiffs served extensive discovery demands seeking an abundance of documents from 2012 to date and defendant moved for a protective order. The lower court essentially allowed the floodgates of discovery to spring open without ever considering the substantive issues presented on the motion for a protective order and the subsequent motion to renew and reargue. On appeal, the First Department also failed to consider substantive arguments, despite the affidavit of the risk manager attesting to the applicable privileges, the enormity of the requests and how the efforts to respond would detract from patient care. Extensive and burdensome pre-certification discovery is thus proceeding, and the issue of class certification has yet to be resolved.

In Fleming v Barnwell Nursing Home and Health Facilities, Inc., plaintiff commenced an action against the defendant nursing home alleging medical malpractice, negligence and wrongful death after the plaintiff-decedent, a resident of the home, developed septic shock from an infection and subsequently passed away. Following the decedent's death, the Department of Health (DOH) investigated the facility and found numerous violations of DOH regulations. Plaintiff thereafter moved to amend his complaint to add a cause of action pursuant to PHL§2801-d, and for class action certification of the claims based on §2801-d and in negligence. The trial court permitted the amendment to the complaint, but denied class certification. Plaintiff and defendant both appealed.

In discussing the class certification, the Third Department noted that an action by a resident of a residential health care facility may be brought as a class action if the prerequisites to class certification set forth in CPLR article 9 are satisfied. However, the Court noted that questions of law or fact common to the class must predominate over questions relating to individual class members, and because there was a lack of common question predominance, plaintiff failed to establish all the requirements of CPLR § 901 for the negligence claim. The Court reached a different result, however, regarding class certification for the PHL §2801-d claim, finding that all of the requirements of both CPLR §901 and §902 were satisfied, and that plaintiff's PHL § 2801-d claim should be certified as a class action.

Five years later, the Fleming case went up on appeal again regarding the terms of the class action settlement. The proposed settlement of the class action on behalf of 242 class members was $950,000, $425,000 of which was approved for class counsel's fees and expenses. Specifically, the Court noted that the case was a complex case that required approximately 1,900 hours of legal services over the course of six years and involved an area of law without much case law to lend guidance. The decision was silent as to whether the lawsuit resulted in facility reform, leading one to question who did this case really benefit? Certainly not the class members, each of whom received approximately $2,169.

Discovery Issues in Nursing Home Class Action Suits

Where plaintiffs seek to certify a class action lawsuit against a nursing home they will inevitably seek discovery of items that are protected under the Quality Assurance Privilege and HIPAA. This will often necessitate a motion for a protective order as occurred in Gibbs. The items demanded by plaintiff in Gibbs included opinion surveys, complaints from residents and/or residents families, complaints from employees or vendors, records of Resident Council meetings, minutes of governing body meetings, documents pertaining to in-house investigations of incidents or conditions at the facility giving rise to the lawsuit, staffing schedules and assignment sheets, time clock and time sheets for all employees, payroll expenditures, documents reflecting labor distribution and employee turnover, documents created by or for and submitted to or from the

Department of Health, documents created by or for and submitted to or from the Centers of Medicare and Medicaid Services, and policies and procedures. The sheer volume of documents and manpower that responses would require should have conceivably resulted in the court substantially curtailing the demands even before considering the applicable privileges and issues or relevance. Unfortunately, that was not the case.

While another motion for protective order is currently pending in *Gibbs* due to the lack of a substantive determination by the courts regarding the demanded discovery, it is feared that the current rulings could lead to an abusive environment of high-cost discovery and the continuous breach of privileges relied upon by nursing homes and medical facilities.

QA Privilege

The Quality Assurance ("QA") Privilege is recognized by both federal and New York law. The Federal Nursing Home Reform Act, 42 U.S.C. § 1395-3(b)(1)(B), provides that a skilled nursing facility must maintain a quality assessment and assurance committee to identify issues with respect to which such activities are necessary and to develop and implement appropriate plans of action to correct and identify quality deficiencies. The records of such committees are privileged and protected from disclosure.

New York Education Law § 6527, 10 NYCRR § 415, and New York Public Health Law §§ 2805-m, 2805-l and 2805-J provide that nursing homes must have a QA committee to review the services rendered to improve the quality of care and to prevent malpractice. That committee must maintain and collect information concerning the facility's experience with negative healthcare outcomes, incidents injurious to patients, and patient grievances, among other things. Neither the proceedings nor the records relating to performance of a medical or quality assurance review function shall be subject to disclosure under the CPLR. Importantly, courts have held that the legislative policy providing confidentiality to Quality Assurance proceedings and investigations outweighs a plaintiff's need for evidence to prove a claim. In the Matter of the Subpoena Duces Tecum to Jane Doe, 99 NY2d 434 (2018); Stalker v. Abraham, 69 AD3d 1172 (3rd Dept., 2010); Zion v. New York Hosp., 183 AD2d 386 (1st Dept., 1992).

HIPPA

The class action mechanism also implicates privacy rights. The HIPAA privacy rule, 45 CFR parts 160, 162 and 164, was engineered precisely to protect an individual's right to privacy with respect to their medical records. The privacy rule protects all forms of protected health information ("PHI"), including information and demographic data that relates to the individual's past, present or future physical or mental health condition; the provision of healthcare to the individual; the past present or future payment for the provision of healthcare to the individual; and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. PHI includes many common identifiers like name, address, birthdate, and Social Security number. Notably, HIPAA provides for ways to de-identify health information, including the removal/redaction of specific identifiers of the individual.

According to HIPAA, an entity such as a nursing home, may only disclose PHI in two highly-specific situations: 1) to individuals or their personal representatives specifically when they request access to or an accounting of disclosures of their PHI; and 2) to the U.S. Department of Health and Human Services when it is undertaking a compliance investigation review or enforcement action.

When a facility is a party to a legal proceeding, the covered entity may use or disclose protected health information for purposes of the litigation as part of its health care operations. However, non-party facility residents – who have not chosen to participate in a class action or been compelled to do so by court order – are entitled to protection of their statutory rights to medical privacy and confidentiality of their PHI under HIPAA. Again, *Olmann* is instructive. There, the lower court and Appellate Division both denied the putative class plaintiff's application for order allowing for disclosure of PHI of non-party residents as "premature and overly broad". Compare Gibbs where the lower court allowed the disclosure of PHI pursuant to a qualified protective order.

Some courts have held that, unless and until a class is certified, the asserted claims in a proposed class action are solely those of the named plaintiffs individually, and discovery should be addressed exclusively to those individual claims. *See* Police & Fire Ret. Sys. of City of Detroit v. IndyMac MBS, Inc., 721 F.3d 95, 112 n.22 (2d Cir. 2013). See Gabriels v. Vassar Bros. Hosp., 135 AD3d 903 (2d Dept., 2016). Numerous other New York courts (both state courts and federal courts sitting in New York) have sought to balance requesting parties' needs to gather evidence in support of their claims against the privacy interests of non-parties. These courts have allowed medical care facilities and similar holders of PHI who are parties to those suits to redact that information from the production of medical records and other documents, even

where the court had previously entered a Qualified HIPAA Protective Order. See, e.g., Sunderland v. Suffolk Cnty., 2017 U.S. Dist. Lexis 221835 (E.D.N.Y. Sept. 29, 2017); Babcock v C-Tech Collections, Inc., 2014 U.S. Dist. Lexis 112425 (E.D.N.Y. Aug. 11, 2014); In re Zyprexa Prods. Liab. Litig., 254 F.R.D. 50 (E.D.N.Y. 2008); National Abortion Fed'n v Ashcroft, 2004 U.S. Dist. Lexis 4530 (S.D.N.Y. Mar. 18, 2004); McMahon v. New York Organ Donor Network, 161 A.D.3d 680 (1st Dep't 2018); Chapman v. Health & Hosp. Corp., 7 Misc. 3d 933 (Sup. Ct., N.Y. Cnty. 2005).

Who Should Bear Costs of Class Actions?

A significant issue with class action litigation is cost allocation, i.e., who should bear the burden of the immense amount of paper discovery. In *Olmann* plaintiff argued that the facility should bear the entire cost of production of the myriad documents plaintiff sought, a prospect that would have crippled the facility from an administrative and personnel function. In the lower court motion practice on the cost allocation issue, defendant argued that the case law established that the party requesting discovery should bear the costs of production and if plaintiff believed in the merits of their claim they should pay the costs associated with their demands. Favorably, as plaintiff's class certification motion was denied and their discovery was necessarily curtailed as a result, the court properly held that plaintiff bore the burden of production.

Contrast *Olmann* with the Supreme Court of Westchester County's approach in *Allen v. Yertle*. There, plaintiff sought electronically stored information for a seven-month period, including data from the owners' personal email accounts. Defendant also sought to have plaintiffs pay for the costs for photocopying, scanning, and producing documents for potential class members, which amounted to 543,563 pages of documents and 10,482 native files.

Despite defendant's arguments, the court refused to apply a cost-shifting analysis. Frankly, the decision hinged in part on the defendant's insurance coverage as the court felt that policy limits of $1/3 million were sufficient to absorb the costs of production.

Insurance Coverage for Class Action Suits

Any discussion concerning costs of litigation necessitates an inquiry into the issue of professional liability insurance coverage. When an entity is faced with a class action lawsuit based on professional liability, it is essential that the entity look to determine whether or not it has insurance coverage for the matter. As a general rule, unless something is specifically excluded in the policy or the alleged wrongful acts preclude coverage by operation of law (i.e., illegal, intentional acts, etc.), there will be coverage for a class action based on professional liability. However, because it is a class action, the per incident limit of liability will apply to all members of the class, as opposed to each member of the class having their own separate individual per claim limit. As such, in a matter where the alleged injuries may be consistent with low exposure, if there are numerous claims, the per occurrence aggregate limit can easily be reached, despite the minor severity of the actual injuries alleged. Therefore, it is essential that in situations where it has been determined that there is insurance coverage for the matter, defense counsel, the insured, and the insurer need to communicate early on in the litigation about the theoretical exposure of the matter and whether or not the insurance in place is adequate to protect the insured from any direct liability.

Along the same line, many professional liability policies are what are known as cost erosive policies. This means that defense counsel fees and related litigation expenses (i.e., expert witness fees, electronic discovery services, medical records, etc.) incurred reduce the amount of insurance coverage available to cover any indemnity losses. It is not an understatement to emphasize that defending a class action, even a small one, has the potential to become very expensive to defend. Defense counsel can easily run up hundreds of thousands of dollars in legal fees and expenses through the early stages of a class action merely investigating each claim that is made, coupled with the complex legal issues inherent in class action lawsuits. Once again, communication amongst the insured, defense counsel, and the insurer is essential in determining whether or not resolution should be sought, even if just for economic reasons, based upon the fact that the cost to defend the matter may significantly erode the insurance coverage leaving the insured and its assets exposed[5]. It is essential that defense counsel manage its ethical duties to the insured in providing a zealous defense, while at the same time making sure that the client's indemnity protection remains intact. These can be difficult worlds to navigate and an early evaluation is essential to determine whether or not early resolution should be sought.

As discussed, a class action in this realm is the exception, not the norm. Thus, decertification of the purported class may very well be the norm, not the exception. From an insurance standpoint, this necessitates an analysis of what are known as "related claims". At first blush this may seem to be a blessing for the insured. If the claims have minimal exposure and there is a separate per occurrence limit, the insured may feel that it is adequately protected, since the annual aggregate on the policy is often higher than the per occurrence limit. For example, if a class action is brought on behalf of 50 patients and all have injuries that are worth $20,000, it is easy to see how the insured may be worried that there will be personal exposure in a class action. However, if

the class is not certified, then the insured will feel more comfortable because while there may be 50 claims, due to the low exposure, none will approach the typical per claim limit of $1,000,000, and the insured's only concern about personal exposure will be if the typical $3,000,000 annual aggregate is met, which is not likely. What the insured and defense counsel need to be aware of in these situations are what is known as related claims. A related claim means a claim alleging, arising out of, based upon or attributable to any facts or wrongful acts that are the same as or related to those that were alleged in another claim made against an insured[6]. It is easy to see a situation where a class is decertified based upon varying factors and the injuries alleged, but the allegations of negligence made against the nursing home are systemic in nature, i.e. a series of related incidents, and are interpreted by the insurer as related claims. What this means is that the insured will take the position that, despite the decertification of the class, all the different claims are really one related claim and, as such, the per occurrence limit will apply to all the claims, as opposed to each individual member of the decertified class having access to the primary per occurrence limit. Further, the applicable aggregate limit will be for the policy period when the first incident is alleged to have occurred. Thus, the security of the decertification of the class providing ample insurance protection is clearly in danger if an insured takes a related claims stance. If this situation were to occur, it would be imperative that the insured retain separate coverage counsel to analyze the insurer's decision and determine whether or not there are any available remedies under the policy and local law.

In short, from an insurance perspective, nursing home class actions are fraught with danger. Based upon the sheer number of the plaintiffs, the chance for personal liability by the defendants over and above the limits of insurance is a very real possibility, and must be analyzed, along with the typical liability and damages analysis.

Conclusion

Studies concerning class actions have found that class members recover little or nothing as a result of the litigation. Accordingly, this begs the question of who benefits from the class action mechanism? Certainly not all residents, many of whom are elderly, have cognitive impairments, reside in the very facilities being sued and in other instances, may be deceased. Indeed, this was the case in *Fleming.*

Any class action against a nursing home should be scrutinized and challenged at the inception of the claim. As New York permits liberal discovery, motions to dismiss or strike class action allegations at the pleading stage are relatively uncommon. They should not be. Class actions are long, complex and costly, and where nursing homes are concerned, they can be seriously disruptive and burdensome. While legitimately harmed residents deserve legal justice, long-term facility defendants are equally deserving of not being exposed to class actions based on presumption or speculation of harm.

Reference on page 40

About the Authors



Mario C. Giannettino is a partner in the law office of Kaufman Borgeest & Ryan, LLP and practices in the firm's Medical Malpractice, Nursing Home and Long Care and General Litigation groups. Throughout his career Mario has represented a wide range of healthcare professionals and providers, including residential healthcare and assisted living facilities, physicians, physician's assistants, hospitals and home healthcare agencies. Moreover, at the outset of the COVID-19 emergency, Mario prioritized the needs of healthcare clients to help them address the extraordinary legal, regulatory and compliance challenges they were now facing. He has published extensively on pandemic-related legal issues.



Kenneth Fox is a partner at McAloon & Friedman, P.C. where he specializes in the representation of physicians, healthcare providers, hospitals, and related facilities in all aspects of professional liability litigation. Mr. Fox also serves as Counsel and Claims Administrator for a major healthcare provider's National Insurance Program where he advises on risk management issues in healthcare, general liability, employment, and Directors and Officers matters. He received his Bachelor of Arts degree in English from Tufts University and his Juris Doctor from the Hofstra University School of Law and has been recognized by his peers having been named to *Super Lawyers* and the *International Advisory Experts Group*. Mr. Fox joined AHRMNY in 2008 and has been a member of the AHRMNY Publications Committee since 2014.



Samantha E. Quinn is a partner with the firm of Schiavetti, Corgan, DiEdwards, Weinberg & Nicholson, LLP, which specializes in the defense of hospitals, doctors and other health care providers. She heads the office's appellate practice, and has briefed and argued numerous appeals. She has also had significant success overturning unsuccessful verdicts, including dismissal of several multi-million dollar verdicts later upheld on appeal. Ms. Quinn has handled OPMC investigations for individual physicians, treatment over objection applications for hospital clients and has counseled hospital clients during the course of DOH investigations and other quality assurance matters.



Stephanie Campbell is a partner at Schiavetti Corgan DiEdwards Weinberg & Nicholson, LLP where she defends hospitals, health systems and individual practitioners in complex medical malpractice and general liability claims. In defense of hospitals and practitioners, she frequently drafts and argues complex motions and appeals before the Supreme and Appellate Courts of the State of New York. She is also licensed to practice law in Connecticut. She became a member of ASHRM and AHRMNY in 2018 and has attended the ASHRM conferences in Nashville and Baltimore. She currently serves on the AHRMNY Publications Committee.



ASHRM held its annual conference on September 11-14, 2022 in Boston. Leaders and aspiring risk professionals gathered for this exceptional event in Healthcare Risk Management.

Opening Keynote speaker, Shola Richards, Civility Champion and Movement Founder spoke about "Staying Strong During Any Challenge" and to reminded us all to "just be kind". Ian Morrison's Keynote address offered insight into "What's Next in Healthcare". Case law updates were presented by AHRMNY NY Chapter Member, Christopher Allman, JD, CPHRM, DFASHRM. Closing keynote speaker, Scott Burrows, motivational speaker and author showed us "How to Stand Up to Any Challenge".

ASHRM Keynote Panel Presentation, on the important topic of Workplace Violence (WPV) –"Where Do We Go From here?" Panel was moderated by ASHRM president, Barbara McCarthy, and included Karen Garvey, Tatum O'Sullivan, Lisa Terry and AHSRM Advisory Board Member and AHRMNY NY Chapter Member, Elaine Ziemba. This discussion on the current state of WPV in HC included interventions to enhance WPV programs, as well as ways to network with groups to support and build in-house WPV programs and internal activities.

During the day, the Solutions Center offered a place to catch up and explore new innovations in Risk. There were over 60 educational sessions presented by some of the most distinguished risk professionals who, did not disappoint. In the evening, there were special events to relax and unwind from the busy day. AHRMNY hosted a successful cocktail party at Howl at the Moon. It was a great chance to connect with so many of our colleagues, we had not seen in a long time and meet new friends as well.

Part of AHRMNY's Mission is to enhance the quality of the delivery of health services and the professional practice of healthcare risk management through educational activities to strengthen the development of healthcare and healthcare related risk management programs and promote professional development of related staff. This was evident by several AHRMNY New York Chapter Members who presented at ASHRM including:

A Proven Enterprise Approach to Address Workplace Violence
Elaine Ziemba, Stanford Health Care/Stanford Medicine

Opportunities and Challenges with Open Notes/ Information Blocking Rule
Mike Midgley, Munich Re Specialty Insurance
Dawn Pignatelli, Bartlett LLP

Shouldering the Responsibilities: Implementation of a Collaborative Shoulder Dystocia Initiative
Dr. David Feldman, Shelise Valentine, and Andrea Patram
The Doctors Company / Healthcare Risk Advisors

Artificial Intelligence: The "Risk" is Not Artificial
Janell Forget, UMASS Memorial Health Care

Bias: An Issue Health Care Can No Longer Afford to Avoid
Ann Huben-Kearney, AWAC Services, Allied World

They "Claim" the Opioid Crisis is Better!
Janell Forget, UMASS Memorial Health Care

Stop the Madness! Strategies to Convert from a Reactive to a Proactive Risk Management Program
Elaine Ziemba, Stanford Health Care/Stanford Medicine

Aon/ASHRM Hospital and Physician Liability 2022 Benchmark Report
Richard Henderson, TransRe
Drew Graham, Hall Booth Smith, PC

Risk Management Data Panel: How to Develop a Meaningful Data Program To Tell Your Story
Josh Hyatt, Coverys

High Stakes Communication with Physicians
Tracy Melina, Nuvance Health

Case Law Update 2022
Christopher Allman, Trinity Health

AHRMNY continues to be a central source of information in New York State on emerging developments and trends in healthcare risk management.

2022 NEW YORK CHAPTER EVENT

Finally! We were live, learning, and networking. The New York Risk Management Chapter (AHRMNY) hosted a party in Boston during the ASHRM Annual Conference on Tuesday, September 13th at the infamous Howl at the Moon. 140 members and guests attended. We look forward to seeing you in Minneapolis next year.













We Thank our Sponsors who Generously Supported our Event

FUMUSO, KELLY, SWART, FARRELL, POLIN & CHRISTESEN LLP

kbr
KAUFMAN BORGEEST & RYAN LLP

USI



Sponsor Specialty Drinks

USI Margarita
Don Julio Tequila
Triple Sec
Sour Mix
Lime Juice

Kaufman Borgeest
Beyond a Reasonable Stout
Guinness

The Fumuso
Equal Parts
Makers Mark
Crown Royal &
Sweet Vermouth
with a cherry



Risk Considerations for Using Surveillance Cameras in Healthcare Practices

By Marcy A. Metzgar



Some providers are installing surveillance cameras in their healthcare practices. They may choose to do so because they want to protect and secure the equipment, records, and medications in their offices; their employees; and their patients. Some wish to prevent access into their practices by unauthorized individuals that may result in theft, violence, or patient record violations. Others want to prevent any physical or verbal abuse that may occur. And some appreciate being able to monitor their practices remotely.

These providers should carefully consider the purpose for installing surveillance cameras to balance their security concerns with their obligation to safeguard their patients' protected health information (PHI) and comply with HIPAA privacy and security requirements. No specific federal rule addresses surveillance cameras in medical or dental offices. However, it's imperative that providers are aware of their state laws and regulations that apply to recording. For example, some states allow audio recording if at least one party to the conversation consents. In other states, all parties must consent to the recording. State laws also might differ regarding telephone versus in-person recording requirements.[1]

Before installing surveillance systems, providers should devise a written policy that identifies their purpose for doing so, the locations of the security cameras, employee notification method, signage posting, system security, privacy considerations, and archiving. The policy should include how the data will be securely stored, how the footage showing an incident from the security cameras will be maintained, as well as specify who will manage the system, who will have access to the files, and under what circumstances.

Providers should determine the type of surveillance that is most appropriate and lawful in their state — live monitoring vs. recording — and include procedures in their written policy regarding the retention and release of recorded video. Depending on state law, providers may also need to be prepared to respond to legal and patient requests to view surveillance tapes or supply a copy of the recordings.

Since the laws and regulations differ from state to state, providers also may consider consulting their professional liability carrier, an attorney, or a compliance officer to discuss recording as well as HIPAA implications.

Here are some steps to take when installing surveillance cameras:[2]

- Install security cameras in visible (not concealed) common areas, such as the waiting room. You may also choose to put video surveillance in areas where important equipment is placed or where prescription medications are stored. Cameras should not be placed in exam rooms, bathrooms, employee lunch or break rooms, or other areas where patients and employees have a reasonable expectation of privacy.
- Ensure that the system is secured both physically (i.e., locked in a cabinet) and digitally (i.e., password protected).
- Ensure that the cameras are positioned to avoid any view of patients' PHI, including information on charts or a computer screen.
- Inform all employees, in writing, that surveillance cameras are being used in the office. Your employees also should sign an acknowledgment form about the cameras, which should be filed in their human resources file.
- Post signage indicating that security cameras are in use. If 5 percent or more of your patients do not speak English, ensure that the signage appears in a second language.
- Consider having your patients sign consent forms that indicate video security is in place. Include on this form how long you intend to store video data that could include recordings of patients.

For information related to patients wishing to record audio or video in healthcare practices, see MedPro's *Risk Q&A: Audio/Video Recording in Healthcare Practices*

Article References on Page 40

About the Author
Marcy A. Metzgar serves as medical writer, editor, and content developer for MedPro Group's Risk Solutions Department.

The Liability Issues of 'Medispa' Treatment

By Kathleen Harth and Elizabeth Ollinick

Physicians seeking to expand their medical practices to include aesthetic services often do so through the establishment of, or contractual affiliation with, a medical spa, or 'medispa.'

While medispa services may present an exciting opportunity to expand service offerings, caution is necessary. Physicians and professional practices face claims for liability arising out of the injuries that can occur from cosmetic treatments gone wrong, even when no physician is directly involved in the treatment. In addition, improperly structured arrangements between a nonmedical entity providing management services to the medispa and a professional corporation providing the medical services may subject physicians to regulatory action.

Before establishing or entering a contractual relationship to provide medical services to a medispa, physicians should consider the professional and financial risks they may face. Liability could be imposed for regulatory violations, false advertising, fraudulent misrepresentation, negligence, and malpractice. In addition, the actions of the spa may bear on the physician's medical license and reputation.

It is important to remember that many services provided by a medispa, such as Botox and chemical peels, constitute the practice of medicine, which is highly regulated in New York. Under the New York State Corporate Practice of Medicine doctrine, only a physician can own a medical practice, and a physician must make clinically related decisions such as the hiring of clinical staff. As a result, plaintiffs claiming injury from a medispa service will likely name the professional practice as a defendant, even if the service at issue was not medical in nature, and even if a physician shareholder was not directly involved in the treatment.

A consulting or supervising physician should be aware that they may bear the burden of liability for any medical malpractice or negligence claims related to the administration of the treatment. While physicians in medispas often delegate procedures to nonphysicians, such as nurses, physician assistants, aestheticians, cosmetologists, and unlicensed technicians, the fact that the physician is not involved in the treatment may be an insufficient basis for dismissal from a legal action.

In addition to malpractice, a cause of action for failure to supervise and inadequate training may stand against a medical director. Even consulting physicians with more tenuous relationships to a medispa may have difficulty obtaining early dismissal, particularly if they are held out to the public as providing medical supervision to the medispa. Such consulting and supervising physicians should be wary of marketing materials that mischaracterize the relationship between the physician and the medispa. Contracting physicians having little control over the medispa's marketing practices may want to discuss with healthcare counsel the suitability of including in their contracts a "use of name" provision backed by a solid indemnification obligation on the part of the medispa.

Supervision, Communication, and Training

It is imperative that the physician owners of medispas establish and communicate objective standards of care and conduct to be followed for all treatments, both medical and nonmedical. Such standards should be consistent with prevailing standards even if the treatments are not medical in nature (e.g., laser hair removal).

Providers and Practices Should:

- Establish mechanisms to monitor the ongoing performance of delivering treatment, including compliance with pertinent policies and procedures such as record keeping, consultation, and communication.
- Ensure that the medispa has written protocols governing safety procedures for the use of equipment and products used by the medispa and maintain documentation of staff training.
- Establish protocols for the physician review of records on a specified and reasonable periodic basis and require staff to check in regularly with supervisors to discuss any potential risk issues or complications.
- Consider documenting record reviews and significant communications.
- Establish written policies and procedures covering treatment errors.
- Document, investigate, and implement corrective action plans for any reported incidents.
- Train staff to take seriously, address, report, and document all patient or client complaints related to treatment.
- Consider establishing follow-up protocols for any patients or clients who express concerns during treatment.
- Ensure that all staff, licensed and unlicensed, remain mindful that even the nonmedical services affect the integrity of a physical body and a person's physical appearance even though treatments performed in a medispa are marketed as "pampering." In addition to causing medical issues, such as burns, scars, and infections, errors in the provision of aesthetic services can also cause significant emotional distress.

Who is Providing the Services?

Significant integration between the professional practice and the nonprofessional entity raises the risk of liability to the

professional practice. Physicians and professional practices wishing to avoid the liabilities of medispas should consider using separate websites and other marketing materials and avoid using documents bearing the name of the medispa. Documents such as informed consents and billing statements should list only the name of the providing entity; either the professional practice or the medispa. Providers should review public-facing materials such as websites and social media sites to determine how the relationship between the entities appears to the public. Would it be reasonable for a person looking for medispa services online to believe that the provider or the professional corporation provides medical supervision of the medispa? If the answer is yes, providers should understand that this appearance leaves them open to liability for the actions of the medispa if a patient or client relies on this appearance when choosing the services of the medispa.

If the public-facing information inaccurately represents the amount of supervision and control the physician or the professional practice provides to the medispa, physicians should ensure that the information is corrected. Otherwise, defending a claim of fraudulent misrepresentation could prove challenging. Providers should also consider the wisdom of sharing office space or equipment with the medispa, renting space in the same building, and sharing staff. A defense of non-association will barely pass the red-face test, let alone support a motion to dismiss, if the provider has the same address as the medispa, and the ostensibly separate entities share staff, equipment, marketing materials, documents, electronic medical records systems, and administrative and operational documents.

Considerations of Professional Standards

While providing medical director services to a medispa may be an exciting way to expand the scope of practice, there should be no appearance that a physician is "selling" their license or providing supervision to a medispa in name only. Physicians should not lend their names to a medispa if they have no intention of providing sufficient supervision of services. In addition, physicians who contract to provide medical director or consulting services to a medispa should have sufficient training in the treatments provided by the spa. While physicians may practice outside their specialty areas, they should consider the risk of providing supervision or consultation services to a medispa if the services performed, including the equipment and products used to administer treatment, are outside their training. The consulting or supervising physician has a professional responsibility to ensure that he or she is competent to provide counsel and supervision of the treatments being provided. In addition to the risk of litigation, failure in this area could compromise a physician's license, professional standing, and reputation.

Regulatory Uncertainty

The practice of medicine is highly regulated, and the law has not kept up with the rapid emergence of medispas. Due to ambiguities in the law, physicians involved with medispas contend with regulatory compliance and enforcement uncertainty. It is critical that providers stay abreast of legal developments. Medispa owners must determine which of the services they offer would constitute "medical treatment," who can perform those services, and under what conditions. If supervision is required, providers must determine the appropriate oversight. For example, at present, anyone can provide laser hair removal treatment. The law requires no license, training, or supervision to provide such treatment.

Providers should be aware, however, that a bill contemplating regulation of laser hair removal passed the New York State Senate in June and is now pending in the Assembly. If passed, the legislation and ensuing regulations would provide administrative and disciplinary oversight of laser hair removal technicians and the facilities where they practice. Among other requirements, technicians will need to meet competency requirements for licensed estheticians and facilities will need to maintain a minimum of $1 million in liability insurance.

In addition to staying abreast of legal developments, prudent providers will retain experienced healthcare counsel to properly structure medispa businesses and ensure that financial arrangements, such as medical director and consulting physician agreements, are not viewed as illegal inducements for referrals.

In sum, as the following cases illustrate, providers entering the world of the medispa should be aware that the venture is not without risk and should proceed with caution.

Case Study #1
Negligent Treatment by Aesthetician Results in Burn

A 61-year-old married female was treated in the MLMIC-insured's dermatology office by a licensed aesthetician who was trained in chemical peels. The patient had been treated by the aesthetician for 11 years for a variety of procedures, including chemical peels of her hands.

On the date in question, the patient came to the office for a facial and subsequently requested laser treatments for the age spots on her hands. Since this was a procedure that had to be scheduled in advance, the patient requested a chemical peel instead. The aesthetician looked for a bottle of Jessner's Peel and, when she was unable to find it, she went to the nurse's closet and retrieved a bottle of trichloroacetic acid.

The following day, the aesthetician went to the patient's home and the patient advised her that she had seen another dermatologist, who confirmed that she had been burned by the acid peel. The aesthetician did not inform the MLMIC-insured dermatologist of this incident; however, the patient and her husband came to the office the following week and informed him of what had transpired. This dermatologist

treated the patient and referred her to the burn unit of a local medical center. The patient remained under the care of another dermatologist for the next 6 months.

The patient subsequently filed a lawsuit alleging negligent treatment that resulted in skin, muscle, bone, connective tissue, and nerve necrosis, as well as blistering, chronic wound opening and drainage, pain, numbness, neuropathy, cellulitis, and inflammation. These injuries were confirmed during an independent medical exam conducted by a cosmetic dermatologist, who noted permanent scarring, discoloration, and disfigurement.

MLMIC's consultant dermatologist felt that despite the aesthetician being trained, she did not read the label and, thus, the patient was treated with the wrong solution. In addition, the aesthetician had no supervision, and our insured dermatologist was not in the practice of reviewing her notes.

As this matter could not be defended, and because the aesthetician had no insurance, our insured dermatologist agreed that the matter should be settled, and the case was eventually settled for $450,000.

Case Study #2
Medical Office with Related Spa May Not Be as It Appears

A 45-year-old single female had searched for a laser hair removal facility and found the website for the MLMIC-insured dermatologist's office, which featured the services of the spa. The patient made an appointment and originally arrived at our insured's office, but was directed to another floor, where laser hair removal was performed. The client questioned whether she needed to see a physician prior to the laser hair removal and was told she did not.

The employee of the spa had received a certificate from the Aesthetics Science Institute as well as training by the spa and the laser manufacturer. Prior to the procedure, the employee explained the risks and benefits, including the possibility of hyperpigmentation and burns. She then performed laser hair removal on the patient's chin.

The patient returned one month later and was informed that there was a new, improved machine, which was used at this time. This treatment took approximately 15 minutes. The patient complained of the intensity during the procedure, but was told this was normal. The patient noted tingling after the treatment and used an ice pack on the skin for the rest of the day. The next morning, she noted blistering and went to the emergency room, where she was diagnosed with a burn and prescribed a cream. She continued to experience discomfort and made an appointment with a burn center, where she underwent multiple skin debridements and was diagnosed with a second-degree burn. She was provided with home nursing care to assist with dressing changes.

The patient subsequently brought an action against the MLMIC-insured dermatologist, her professional corporation, and the non-MLMIC-insured spa, alleging negligent laser hair removal that resulted in facial burns.

The spa was not overseen by the dermatologist or her professional entity, and its employees performed nonmedical services. The professional entity provided management services to the spa by contract, for which the spa paid a monthly fee for payroll, use of electronic medical records, and administrative services. Each entity maintained its own office space, staff, and phone numbers, and had separate billing and tax ID numbers. They shared some staff and their website and were in the same building. Our insured and her professional entity did not provide care to this patient and maintained no records on her behalf.

Counsel for the dermatologist and her professional entity took the position that they were not involved in this matter, as they never rendered treatment to this patient. They examined the financial contract and informed consent documents that were provided to the patient and noted that the professional entity was listed at the top of the page along with the address and website of the spa. In addition, the papers indicated that the entities were a partnership.

The defense counsel argued that the spa and the dermatology group were actually separate legal entities. The medical supervision referenced in the spa's advertisements referred to the non-party owner of the spa and did not indicate that the medical group ever provided supervision. The laser equipment used during the procedure at issue was not owned or operated by the dermatology group. Therefore, they did not maintain or supervise the use of the equipment, either. As such, the plaintiff's theory would have to resort to vicarious liability to establish culpability for the medical group.

The patient claimed total damages of $350,000. MLMIC's defense counsel continued to pursue a Stipulation of Discontinuance on behalf of our insureds and were ultimately successful in extricating them from this case.

About the Authors



Kathleen Harth is an Assistant Vice President of Claims with MLMIC Insurance Company. **kharth@MLMIC.com**



Elizabeth Ollinick is an attorney with MLMIC Insurance Company. **eollinick@MLMIC.com**

This article originally appeared in MLMIC Insurance Company's *The Scope - Medical Edition*.

Supporting Resilience in Healthcare Workers

By ECRI

In healthcare, as in any field, ensuring that staff members feel fulfilled in their work is an ongoing challenge. The ability on the part of healthcare providers to bounce back amidst the demands of their work contributes fundamentally to patient safety and to the viability, success, and competitiveness of an organization. Staff and clinician resilience helps protect against errors and potential liability, and its cultivation demonstrates genuine concern for team member well-being.

Given the human characteristics best suited for the healthcare workplace, and the range of situations and personalities that staff bring to the workplace, the goal of supporting satisfaction and resilience in the face of stress is ongoing. As a result, the effort to support medical staff resilience and to counter employee burnout and discontent has received growing attention in recent years.

While the COVID-19 pandemic underscored the need for resilience programs, especially for certain segments of healthcare workforce, the World Health Organization had already added burnout to its international Classification of Diseases in 2019 as an occupational phenomenon.[1] And nearly two-thirds of doctors responding to a Medscape survey reported that their burnout symptoms had escalated during the pandemic.[2] The media at national and regional levels, such as CNN, TIME, and The Philadelphia Inquirer, have broadly covered the challenges to resilience among healthcare providers, especially during 2020.

Amid this increasing focus on maintaining staff engagement, managers must appreciate the critical role that resilience measures play by understanding the alternatives—burnout and unhealthful behavioral responses—and their prevalence.

What Are the Challenges to Resilience?

"Personal resilience is the individual ability to withstand, adapt to, and recover from adversity and stress."[3] It refers to the basic constitution of individuals and their orientation to life circumstances, and is related to the effects of stress and pain, achievement, and gratification. At the very least, resilience allows a person to endure and persist; and, in better circumstances, it promotes well-being and healthy mental status.

In addition to obvious factors such as workload and provider responsibility to patients, many other conditions challenge the resilience of today's healthcare professional:

- System-generated stressors, including cost cutting and ever-increasing regulations, have resulted in workers feeling less in control while being assigned multiple new tasks without additional time to accomplish the work.
- Physicians, nurses, and support staff, as well as administrators and executives, must cope with a system that produces overtesting, pressures around preauthorizations, issues of access related to referrals, and other barriers inherent in the modern business of healthcare. These may contribute to "moral injury" among providers, especially if they feel they are treating patients within a system that is not working the way it should.[4]
- The prominence of the electronic health record (EHR) has largely increased clinician burden. Physicians cite administrative burden as the leading cause of burnout.[5] As health information technology (IT) continues to evolve, medical staff may believe that the demands of the EHR harm patient care rather than enhance it.
- When adverse events such as serious medical errors occur, providers may feel emotionally traumatized.[6]
- Healthcare has been identified as an industry with its fair share of workplace bullying. This disruptive behavior may take place between physicians, between nurses, or across roles. Bullying can have numerous forms, including personal bullying (belittlement), bullying regarding workplace tasks, and intimidation (threats of abuse or violence). A majority of healthcare providers report being bullied at least once during their careers.[7]
- Other issues ranging from educational debt to threat of litigation or licensing violations are additional stressors that can deplete provider resilience reserves.
- Professional burnout – a complex syndrome of emotional distress due to occupational factors, characterized by feelings of fatigue, cynicism, and decreased self-efficacy – is closely associated and overlaps with depression.[8] Major depression on

the part of a team member may therefore be confused with simple work stress and, therefore, not adequately addressed.

- Mental detachment and a reduced sense of personal accomplishment may occur in both acute and ambulatory settings and may cause an individual to neglect their duties and forget seemingly minor—yet crucial—patient safety measures.[9]

Studies have also found that physicians who suffer from a mental health condition may be unlikely to seek care for a variety of reasons.[10, 11, 12] In addition to fear of what colleagues will think and pressure to prove oneself, these doctors face mandatory disclosure of a mental health history on applications such as state licensing forms. To avoid disclosure, some physicians choose to avoid or hide treatment.[13, 14]

All of these realities work against resilience and have a fundamental impact on a culture of safety.[15] Conversely, factors that are prophylactic for resilience include such variables as quality of sleep, positive emotions, and life satisfaction. Each counters work-day pressures, and although these factors are not easy for an employer to control, a healthcare organization can take important steps to enhance them for its healthcare staff.

A Danger Well Documented

At national and regional levels, the media have broadly covered the challenges among healthcare providers, especially during the COVID-19 pandemic in 2020.[16, 17, 18] Individuals who work in healthcare are disproportionately affected by stress and burnout, a problem associated with low job satisfaction, increased medical errors, alcohol and substance abuse, and impaired interpersonal relationships.[19] Some of the stress contributing to this is not surprising, given the intensity of the environment, the risk to the health of patients, and the gravity of potential medical errors.

Even before the COVID-19 pandemic, burnout among healthcare workers was considered a major issue and among physicians—at crisis levels.[5]

Physicians. Burnout and dissatisfaction with work-life balance were already known to be more common among physicians than among other professionals,[20] although some evidence, for example, indicates that physicians have high levels of resilience compared to other professionals.[21] Doctors are also considered to encounter some of the greatest demands among healthcare workers.[22] Burnout among physicians is associated with unsafe care, unprofessional behavior, and lower levels of patient satisfaction.[20] Likewise, many physicians who report depression indicate that it compromises their interactions with patients.[5]

Actual estimates of physician burnout vary widely,[23] but more than 40% of doctors have reported feeling burned out.[24] In oft-cited surveys, the portion of physicians indicating signs and symptoms consistent with burnout has risen to more than half.[25] In addition, these physicians are more likely to report at least one major medical error in the previous three months.[26]

Substance abuse that causes behavioral problems in physicians and other providers is a serious threat to healthcare quality.[27] Such habits create a safety risk to patients, raising the potential for organizational liability.

Nurses. Nurses are particularly subject to job-related stress, a fact that only worsened in 2020.[28] More than 40% of inpatient nurses reported a high degree of emotional exhaustion in a 2020 survey.[29] Furthermore, female staffers in healthcare may have elevated stress from work-family conflict[30]—as they also continue to earn less money and remain less likely to advance than their male colleagues.[31] Women who work in the healthcare support sector have the third highest suicide rate among women, by occupation.[32]

Acute care organizations. The danger to resilience can also be particularly acute in certain medical service areas, especially for staff on the frontline, such as clinicians in emergency medicine[33] and critical care, some nursing subspecialties, as well as the surgical fields, leading to compensatory behaviors such as drug or alcohol abuse.[31] However, primary care physicians also experience high levels of burnout.[32, 33]

Work environment. Psychological harm is also common in the healthcare industry and contributes to the undermining of resilience among providers. Emotional abuse, sexual abuse, bullying, threats of physical assault, and "learning by humiliation" are often accepted as "normal" conditions of the healthcare workplace, creating a culture of fear and intimidation that can sap caregiver joy and prevent them from finding meaning in their work.[34]

Crises. During peak periods of crisis situations (e.g., COVID-19), issues such as shortage of equipment and personnel, life and death triaging and other ethical situations, restrictions on family member access to their loved ones, staff infection risk, pressure to live up to heroic levels of commitment, and a perceived lack

of effective solutions or support all exacerbate strain on healthcare personnel.[35] Trauma-related stress at such times is common.[36]

Such depletion of resilience reserves results in increased risk to patients, malpractice claims, worker absenteeism and turnover, as well as billions of dollars in losses to the medical industry each year.[37]

Protecting and Guarding an Investment

Staff is without a doubt the most precious resource for any healthcare facility or organization, but regular, proactive maintenance of the personal readiness and capacity of staff members can be overlooked. Not only do overburdened healthcare workers risk developing stress or other health disorders, they may also experience loss of concentration, focus, or judgment, certainly detrimental to patient care.[38] Compromised performance by one provider can also create liability for fellow providers tangentially involved with the care of patients.

The potential consequences of provider burnout include declining quality of care and poorer patient experience—resulting in lower patient satisfaction, increased medical errors, reduced patient access to needed care, higher provider turnover, and decreased provider professionalism. The cynicism that accompanies burnout also has a significant correlation with job turnover.[39]

The fluidity of healthcare employment, in terms of opportunities to move between institutions, makes another business case for guarding staff satisfaction and thus staff stability, in part by supporting resilience. Nearly half of all Millennials (born between 1982 and 2000) planned to leave their jobs within two years, according to speakers at the 2018 American Society for Health Care Risk Management conference in Nashville (October 7-10).[40] Millennials are known as a generation that favors work-life balance and purposeful work. And almost paradoxically, early signs seem to show that the COVID-19 pandemic has stimulated interest in the healthcare professions among young adults—perhaps as a result of the historically admirable and inspiring efforts of the healthcare community during the extended outbreak.[41, 42]

Action Recommendations

- Acknowledge the challenges and realities of job stress and resilience, and promote efforts to address them.
- Seek feedback regarding perceptions of staff resilience as well as organizational programs to foster resilience.
- Involve leadership and all staff members at all levels of the resilience initiative.
- Create a plan that allows for flexibility regarding scheduling and workload and for the development of resilience resources for staff.
- Be open to suggested changes to both the perceived and actual culture, particularly as it relates to employee support.
- Recognize good work and regularly celebrate positive values and commitment.
- Assess resilience and set reasonable expectations on a regular basis.

Article References on Page 40

Reprinted with permission, Copyright 2021, Emergency Care Research Institute d/b/a ECRI. www.ecri.org. 5200 Butler Pike, Plymouth Meeting, PA 19462.

This article is excerpted from ECRI's Health System Risk Management, an online membership offering actionable tools, evidence-based guidance, and practical strategies to anyone involved in managing risk in hospital environments. Learn more at https://www.ecri.org/solutions/health-system-risk-management/.

Citation:
ECRI. Supporting Resilience in Healthcare Workers. Health System Risk Management 2021 Jul 15
https://www.ecri.org/search-results/member-preview/hrc/pages/empl16

New York's Adults Survivor Act (from page 6)

[1] New York's statute of limitations for intentional torts (such as assault or battery) is one year (CPLR § 215(4)).
[2] If the plaintiff was a minor at the time of the abuse, they were afforded one year to pursue claims for intentional torts after reaching the age of majority (CPLR § 208).
[3] CPLR § 215(8)(a).
[4] CPLR § 215(8)(b).
[5] CPLR § 213-b(1).
[6] CPLR § 213-b(2).
[7] New York's statute of limitations for negligence (including negligent hiring or negligent supervision) is three years (CPLR § 214(5)).
[8] Child Victims Act New York deadline passes with 10K lawsuits filed (democratandchronicle.com)
[9] *Holloway v. Holy See*, 2021 U.S. Dist. LEXIS 86196 at fn. 2 (S.D.N.Y. May 5, 2021); *S.H. v. Diocese of Brooklyn*, 2020 N.Y. Misc. LEXIS 4394 at *6 (N.Y. Sup. Ct. Aug. 14, 2020).
[10] Some New York judges have been assigned over 500 CVA cases each, in addition to their already backlogged dockets.
[11] *N.X. v. Cabrini Med. Ctr.*, 97 N.Y.2d 247, 251 (2002); *A.M. v. Holy Resurrection Greek Orthodox Church of Brookville*, 190 A.D.3d 470 (1st Dept. 2021); *Montalvo v. Episcopal Health Servs., Inc.*, 172 A.D.3d 1357 (2d Dept. 2019); *Stribing v. Bill Gray's Inc.*, 166 A.D.3d 1503 (4th Dept. 2018); *Dia C.C. v. Ithaca City Sch. Dist.*, 304 A.D.2d 955 (3d Dept. 2003).
[12] *See, e.g.*, *PB-36 Doe v. Niagara Falls City Sch. Dist.*, 72 Misc. 3d 1052 (Sup. Ct. Niagara Co. July 19, 2021); *AA v. Hammondsport Cent. Sch. Dist.*, 527 F.Supp. 3d 501 (W.D.N.Y. 2021); *Fay v. Troy City Sch. Dist.*, 197 A.D.3d 1423 (3d Dept. 2021).
[13] *Compare Torrey v. Portville Cent. Sch.*, 2020 N.Y.Misc. LEXIS 748 (Sup. Ct. Cattaraugus Co. Feb. 21, 2020) and *PC-41 Doe v. Poly Prep Country Day Sch.*, 2021 U.S. Dist. LEXIS 181254 (E.D.N.Y. Sept. 22, 2021) (breach of fiduciary duty dismissed as duplicative of negligence); *with Matter of M.C. v. State of New York*, 74 Misc.3d 682 (Ct. Cl. Jan. 20, 2022) (Declined to dismiss breach of fiduciary claim).
[14] While the lists themselves may be conditionally privileged as material prepared in anticipation of litigation (CPLR 3101(d)(2), the potential witness' names and contact information are likely discoverable under CPLR § 3101(a).
[15] https://childusa.org/2022sol/

Grieving Families Act (from page 9)

[1] 28.3% of medical liability losses arise from wrongful death claims.
[2] 22.7% of automobile liability losses arise from wrongful death claims.
[3] 9% of general liability losses arise from wrongful death claims.
[4] This analysis does not factor in the increase in the Statute of Limitation, however when the extra 1½ years to commence suit is considered, it is clear that the numbers will be even less favorable.
[5] Again, the additional time to commence a wrongful death lawsuit is not factored. Considering the increased statute of limitations, the GFA will be even more dangerous to self-insureds.
[6] This change would put New York among the states with the longest statute of limitations for wrongful death. 0.5% of America has a 2 year or less statute of limitations. Only 29.5 percent of the nation has a statute of limitations over 2 years. In fact, the proposed 3 ½ year statute of limitations would make New York most generous in terms of statute of limitations in the entire nation.
[7] It is possible that the law will be signed as an "October surprise" for political reasons. Lee Zeldin, the Governor's opponent in the election this fall has made her alleged "complicity in nursing home deaths" a feature of his campaign.

Documents Protected from Discovery (from page 26)

[1] *Olman* is currently pending in a trial court within the Second Department.
[2] *Gibbs* is currently pending in a trial court within the First Department.
[3] *Flemming* was lititgated to settlement in the Third Department.
[4] the plaintiff's proposed class included all residents of the nursing home facility during a one-year period.
[5] The potential for bad faith claims also exists in these types of situations, but that discussion is beyond the scope of this article.
[6] Related claims language from a National Union Fire Insurance Compny of Pittsburgh PA (AIG) Healthcare Professional Liability policy states "All **claims** arising from one **medical incident** or a series of related **medical incidents** to any one **patient** shall be treated and shall be deemed to have occurred at the time of the first **medical incident** regardless of the number of claimants, or the number of **Insureds** against whom such **claims** are made."

Surveillance Cameras in Healthcare Practices (from page 33)

[1] Justia. (2018). Recording phone calls and conversations. Retrieved from www.justia.com/50-state-surveys/recording-phone-calls-and-conversations/
[2] California Dental Association. (2019, October 31). Before recording, protect private patient information. Sacramento, CA: Regulatory Compliance News. Retrieved from www.cda.org/Home/News-and-Events/Newsroom/Article-Details/before-recording-protect-private-patient-information; Valentine, M. (2020, January 24). *Security cameras in the medical office.* Cooperative of American Physicians. Retrieved from https://www.capphysicians.com/articles/security-cameras-medical-office

Resilience in Healthcare Workers (from page 38)

[1] World Health Organization. Burn-out an 'occupational phenomenon': International Classification of Diseases. 2019 May 28 [accessed 2021 Mar 18]. https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases
[2] Kane L. Medscape US and international physicians' COVID-19 experience report: risk, burnout, loneliness. [slide show]. Medscape. 2020 Sep 11 [accessed 2021 Mar 18]. https://www.medscape.com/slideshow/2020-physician-covid-experience-6013151#1
[3] The Resiliency Solution. Resilience in healthcare. [accessed 2021 Mar 18]. https://theresiliencysolution.com/resilience-in-healthcare/
[4] Bailey M. Too many tests, too little time: Doctors say they face 'moral injury' because of a business model that interferes with patient care. Washington Post Online. 2020 Feb 1 [accessed 2021 Mar 18]. https://www.washingtonpost.com/health/too-many-tests-too-little-time-doctors-say-they-face-moral-injury-because-of-a-business-model-that-interferes-with-patient-care/2020/01/31/c00e9d58-3d3a-11ea-8872-5df698785a4e_story.html
[5] Medscape. Medscape national physician burnout & suicide report 2020: the generational divide. [slide show]. 2020 Jan 15 [accessed 2021 Mar 23]. https://www.medscape.com/slideshow/2020-lifestyle-burnout-6012460
[6] Joint Commission. Supporting second victims. Quick Saf. 2018 Jan 22;39:1-3. https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-39-supporting-second-victims/
[7] Sekeres MA. When the bully is a doctor. New York Times. 2018 Jun 14 [accessed 2021 Mar 18]. https://www.nytimes.com/2018/06/14/well/live/doctor-bully-bullying.html?partner=rss&emc=rss
[8] Spector N. Sick as a doc? Doctors are burning out - and it's serious. NBC News. 2017 Oct 31 [accessed 2021 Mar 18] https://www.nbcnews.com/better/health/sick-doc-cases-doctor-burnouts-are-rise-it-s-serious-ncna815936
[9] Patient Safety in the office-based practice setting. Philadelphia (PA): American College of Physicians; 2017. https://www.acponline.org/acp_policy/policies/patient_safety_in_the_office_based_practice_setting_2017.pdf
[10] Guille C, Speller H, Laff R, Epperson CN, Sen S. Utilization and barriers to mental health services among depressed medical interns: a prospective multisite study. J Grad Med Educ. 2010 Jun;2(2):210-4. http://dx.doi.org/10.4300/JGME-D-09-00086.1

[11] Weiner S. Doctors forgo mental health care during pandemic over concerns about licensing, stigma. Association of American Medical Colleges. 2020 Dec 10 [accessed 2021 Mar 18. https://www.aamc.org/news-insights/doctors-forgo-mental-health-care-during-pandemic-over-concerns-about-licensing-stigma

[12] Mehta SS, Edwards ML. Suffering in silence: mental health stigma and physicians' licensing fears. Am J Psychiatry Resid J. 2018 Nov;13(11):2-4. https://doi.org/10.1176/appi.ajp-rj.2018.131101

[13] Kuhn CM, Flanagan EM. Self-care as a professional imperative: physician burnout, depression, and suicide. Can J Anaesth. 1 Feb 2017;64(2):158-68. http://dx.doi.org/10.1007/s12630-016-0781-0

[14] Samson D, Schoelles KM. Chapter 2: medical tests guidance (2) developing the topic and structuring systematic reviews of medical tests: utility of PICOTS, analytic frameworks, decision trees, and other frameworks. J Gen Intern Med. 2012 Jun;27 Suppl 1(Suppl 1):S11-9. http://dx.doi.org/10.1007/s11606-012-2007-7

[15] ECRI. 2019 Top 10 patient safety concerns. 2019 [accessed 2021 Mar 18]. https://www.ecri.org/components/HRC/Pages/2019Top10.aspx

[16] Ranney M, Gold J. Doctors: Health care workers are experiencing more than Covid-19 burnout. CNN. 2020 Nov 18 [accessed 2021 Mar 18]. https://www.cnn.com/2020/11/18/opinions/health-care-workers-covid-19-burnout-ranney-gold/index.html

[17] Trianni F. Doctors and nurses talk about burnout as another wave of COVID-19 hits U.S. Time. 2020 Nov 23 [accessed 2020 Mar 18]. https://time.com/5914409/covid-19-health-care-worker-burnout/

[18] Agarwal A. For health-care workers during COVID-19, the burnout is real, and it's getting worse. Expert Opinion. Philadelphia Inquirer. 2020 Dec 1 [accessed 2021 Mar 18]. https://www.inquirer.com/opinion/commentary/covid-coronavirus-healthcare-workers-mental-health-support-20201201.html

[19] Elmore LC, Jeffe DB, Jin L, Awad MM, Turnbull IR. National survey of burnout among US general surgery residents. J Am Coll Surg. 2016 Sep;223(3):440-51. http://dx.doi.org/10.1016/j.jamcollsurg.2016.05.014

[20] Shanafelt TD, Boone S, Tan L, Dyrbye LN, Sotile W, Satele D, West CP, Sloan J, Oreskovich MR. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. Arch Intern Med. 2012 Oct 8;172(18):1377-85. http://dx.doi.org/10.1001/archinternmed.2012.3199

[21] West CP, Dyrbye LN, Sinsky C, Trockel M, Tutty M, Nedelec L, Carlasare LE, Shanafelt TD. Resilience and burnout among physicians and the general US working population. JAMA Netw Open. 2020 Jul 1;3(7):e209385. http://dx.doi.org/10.1001/jamanetworkopen.2020.9385

[22] Bozdag F, Ergün N. Psychological resilience of healthcare professionals during COVID-19 pandemic. Psychol Rep. 2020 Oct 13. http://dx.doi.org/10.1177/0033294120965477

[23] Rotenstein LS, Torre M, Ramos MA, Rosales RC, Guille C, Sen S, Mata DA. Prevalence of burnout among physicians: a systematic review. JAMA. 2018 Sep 18;320(11):1131-50. http://dx.doi.org/10.1001/jama.2018.12777

[24] Page L. Burnout might really be depression; how do doctors cope? Medscape. 2018 Jan 18 [accessed 2021 Mar 18]. https://www.medscape.com/viewarticle/891005_1

[25] Shanafelt TD, Hasan O, Dyrbye LN, Sinsky C, Satele D, Sloan J, West CP. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clin Proc. 2015 Dec;90(12):1600-13. http://dx.doi.org/10.1016/j.mayocp.2015.08.023

[26] Tawfik DS, Profit J, Morgenthaler TI, Satele DV, Sinsky CA, Dyrbye LN, Tutty MA, West CP, Shanafelt TD. Physician burnout, well-being, and work unit safety grades in relationship to reported medical errors. Mayo Clin Proc. 2018 11;93(11):1571-80. http://dx.doi.org/10.1016/j.mayocp.2018.05.014

[27] Han S, Shanafelt TD, Sinsky CA, Awad KM, Dyrbye LN, Fiscus LC, Trockel M, Goh J. Estimating the attributable cost of physician burnout in the United States. Ann Intern Med. 2019 Jun 4;170(11):784-90. http://dx.doi.org/10.7326/M18-1422

[28] Ulrich CM. Nurses are reaching their COVID-19 breaking point. It didn't have to be this way. Philadelphia Inquirer. 2020 Dec 28 [accessed 2021 Mar 18]. https://www.inquirer.com/opinion/commentary/covid-hospital-staffing-nurses-standard-of-care-20201228.html

[29] Clinician Wellbeing Knowledge Hub. Sharing knowledge to combat clinician burnout. Washington (DC): National Academy of Medicine; [accessed 2021 Mar 18] https://nam.edu/clinicianwellbeing/

[30] Guille C, Frank E, Zhao Z, Kalmbach DA, Nietert PJ, Mata DA, Sen S. Work-family conflict and the sex difference in depression among training physicians. JAMA Intern Med. 2017 Dec 1;177(12):1766-72. http://dx.doi.org/10.1001/jamainternmed.2017.5138

[31] Oreskovich MR, Kaups KL, Balch CM, Hanks JB, Satele D, Sloan J, Meredith C, Buhl A, Dyrbye LN, Shanafelt TD. Prevalence of alcohol use disorders among American surgeons. Arch Surg. 2012 Feb;147(2):168-74. http://dx.doi.org/10.1001/archsurg.2011.1481

[32] Peterson C, Stone DM, Marsh SM, Schumacher PK, Tiesman HM, McIntosh WL, Lokey CN, Trudeau AT, Bartholow B, Luo F. Suicide rates by major occupational group—17 States, 2012 and 2015. MMWR Morb Mortal Wkly Rep. 2018 Nov 16;67(45):1253-60. http://dx.doi.org/10.15585/mmwr.mm6745a1

[33] Bauers S. COVID-19 is making ER physician burnout worse than ever. Jefferson, UArts researchers seek ways to help. Philadelphia Inquirer.2020 Dec 29 [accessed 2021 Mar 18]. https://www.inquirer.com/health/coronavirus/physician-burnout-emergency-department-design-jefferson-20201229.html

[34] Lucian Leape Institute. Through the eyes of the workforce: creating joy, meaning, and safer health care. National Patient Safety Foundation. 2013. http://www.ihi.org/resources/Pages/Publications/Through-the-Eyes-of-the-Workforce-Creating-Joy-Meaning-and-Safer-Health-Care.aspx

[35] Kisner J. What the chaos in hospitals is doing to doctors. The Atlantic; 2020 Dec 8 [accessed 2021 Mar 23]. https://www.theatlantic.com/magazine/archive/2021/01/covid-ethics-committee/617261/

[36] Benfante A, Di Tella M, Romeo A, Castelli L. Traumatic stress in healthcare workers during COVID-19 pandemic: a review of the immediate impact. Front Psychol. 2020;11:569935. http://dx.doi.org/10.3389/fpsyg.2020.569935

[37] National Academies of Sciences, Engineering, and Medicine. Taking action against clinician burnout: a systems approach to professional well-being. The National Academies Press. 2019. https://www.nap.edu/download/25521#

[38] Arespacochaga E. Shining a light on physician suicide. American Hospital Association. 2020 Sep 17 [accessed 2021 Jun 04] https://www.aha.org/news/blog/2020-09-17-shining-light-physician-suicide

[39] Patel RS, Bachu R, Adikey A, Malik M, Shah M. Factors related to physician burnout and its consequences: a review. Behav Sci (Basel). 2018 Oct 25;8(11):98. http://dx.doi.org/10.3390/bs8110098

[40] ECRI. Are you doing enough to develop and retain your millennials? 2018 Oct 24 [accessed 2021 Mar 19]. https://www.ecri.org/components/HRCAlerts/Pages/HRCAlerts102418_Millennials.aspx

[41] Snyder S. A byproduct of the pandemic? Colleges see soaring interest in health fields. Philadelphia Inquirer. 2020 Dec 21 [accessed 2021 Mar 19]. https://www.inquirer.com/education/temple-drexel-penn-applications-medical-school-up-public-health-20201219.html?utm_medium=referral&utm_source=ios&utm_campaign=app_ios_homefeed_share&utm_content=WGITM46JBJF5ZGVR75IYGLIL5Y

[42] Murphy B. Applications to medical school up big. Is it the Fauci effect? American Medical Association. 2020 Dec 18 [accessed 2021 Mar 19]. https://www.ama-assn.org/residents-students/preparing-medical-school/applications-medical-school-big-it-fauci-effect

A H R M N Y

RISK MANAGEMENT JOURNAL

The Association for Healthcare Risk Management of New York, Inc.
PO Box 4200, Grand Central Station
New York, NY 10163

AHRMNY does not endorse, recommend or favor any organization, author or product discussed in this journal.

Click here for a current list of AHRMNY's Officers and Directors