DEFENSE PRACTICE UPDATE

MARTIN CLEARWATER & BELL LLP

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New York State Adopts Advanced Home Health Aides Law

By: Karen B. Corbett and Maria Stavrakis

New York State (NYS) recently passed legislation that establishes the job designation of an Advanced Home Health Aide (AHHA). Under this law, an AHHA may perform advanced tasks previously performed by Licensed Practical Nurses (LPNs). Governor Andrew Cuomo signed S. 8110/A.10707 into law on November 28, 2016 and it became effective on May 28, 2018. The Department of Education then published guidelines related to the scope of an AHAA's practice under the new law.

Pursuant to NYCRR 794.3(k), an AHHA candidate must attend a NYS approved training program to obtain a certification permitting them to work as an AHHA. They must take and pass the MACE (Medication Administration Certification Examination) within 180 days from the start of the class and in order to practice as an AHHA they must be a certified HHA, have at least one year of experience working as a Certified Nursing Assistant (CNA)/Home Health Aide (HHA) and be at least 18 years of age with a high school diploma or GED.

Under this law, an AHHA may perform advanced tasks previously performed by Licensed Practical Nurses (LPNs).

The candidate must be able to read, write and speak English and must be able to perform basic math skills. Finally, they must complete a minimum of 18 hours of annual in-service training after receiving their AHHA certificate.

An AHHA, under the supervision of a registered nurse, is able to perform advanced tasks. Advanced tasks are tasks that were customarily performed by LPNs in a patient's home. With this new law, AHHAs will be certified to administer medications which are routinely taken by the patient (orally, in the eye or ear, nasally, on the skin, vaginally, rectally, inhaled through the nose or mouth); administer injections of low molecular weight heparin or diabetes medications; and administer injections of epinephrine, nalox-

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one or glucagon. Advanced tasks that will not be included in the expanded role of an AHHA are functions such as deciding whether a patient needs a PRN medication; administering medications through feeding tubes such as gastrostomy or nasogastric tubs; any tasks involving the use of intravenous or subcutaneous infusion devices, use of mechanical ventilator, and a task involving sterile technique other than administration of injections. Finally, tasks involving professional nursing judgment or that are outside of the scope of practice of an LPN will also not be included in the newly identified role of an AHHA.

Only a Registered Nurse (RN) may assign advanced tasks to an AHHA. To make an assignment of an advanced task, a registered nurse must: complete a comprehensive nursing assessment to ascertain the patient's health status and care needs; must determine whether to assign an AHHA to perform any advanced task for the patient; must ensure that the advanced tasks to be assigned is consistent with a physician's, nurse practitioner's or other prescriber's ordered care; must verify that the patient consents to the care to be provided by the AHHA; must train the AHHA to perform the advanced tasks; must assess the AHHA's competency in performing the advanced tasks; must provide the AHHA with written, patient specific instructions for performing the advanced tasks and criteria for identifying, reporting and responding to problems, errors or complications; and must document

Only a Registered Nurse (RN) may assign advanced tasks to an AHHA.

the assignment of advanced tasks to the AHHA in the patient's care plan or health record.

Importantly, both the registered nurse and the AHHA must work for a Department of Health licensed hospice or home care provider working in the patient's home. The registered nurse supervising the AHHA through the advanced tasks must be available to communicate with the AHHA at all times by alternative means such as via telephone, if they are physically present at the same location. The RN must continue to be knowledgeable of the patient's current health status at all times and must perform ongoing assessments of the patient's needs. Additionally, the supervision of the AHHA includes periodic visits to the patient to observe the AHHA providing care.

The purpose of this new law and its long-term goal is to enable more people to live in home and community-based settings and provide support to family caregivers and their loved ones. More importantly, this new law will support patient quality care in various ways. First, the expansive role of the AHHA will more efficiently keep the Supervising Nurse updated regarding the patient's care needs.

Second, the newly assigned tasks of the AHHA will support and improve the patient's medication compliance, resulting in decreasing hospitalization or emergency room visits. Finally, the length of visit time with each patient will be increased thus providing additional support and observation for the patient.

It is recommended that the RN and AHHA familiarize themselves with the requirements under the new law to ensure compliance.

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New York County Supreme Court Grants Summary Judgment and Declines to Extend Physician's Duty of Care

By: Barbara D. Goldberg and Emma B. Glazer

In December 2015, the Court of Appeals recognized a duty of care owed by medical providers to the public at large. In *Davis v. South Nassau Communities Hospital*,[1] the Court held that "where a medical provider has administered to a patient medication that impairs or could impair the patient's ability to safely operate an automobile, the medical provider has a duty to third parties to warn the patient of that danger." *Davis* raised the concern that plaintiffs' attorneys would attempt to further broaden the duty of care to third parties beyond the specific fact pattern in the *Davis* case. In a recent case handled by Martin Clearwater & Bell LLP, we successfully moved for summary judgment arguing that our clients did not owe a duty of care to the patient's wife and that the plaintiff's injury was unforeseeable.

This was a notable victory as the Court declined to extend the duty of care in a case involving a then 48-year-old woman who was visiting her spouse in the Postoperative Care Unit following surgery. Plaintiff claimed that our client physician negligently asked her to hold a flashlight while he sutured a surgical drain in the patient's neck that began leaking. It was claimed that this caused her to faint and fracture her ankle.

In moving for summary judgment, we argued that the defendant Hospital and physician did not owe a duty to the plaintiff as there was no physician-patient relationship. Moreover, the plaintiff voluntarily participated in holding the flashlight. We also argued that the injury was unforeseeable, since merely asking an individual to hold a flashlight cannot reasonably be perceived as posing a risk of harm to that person. Our medical arguments were supported by an Affirmation of a board certified otolaryngologist.

The plaintiff's attorney argued that the lack of a physician-patient relationship was not dispositive of the case as it was claimed that this was a case of general negligence and not medical malpractice. However, we emphasized that controlling case law made clear that even in cases of general negligence, the Courts have been very reluctant to extend a physician's duty of care to non-patients. In fact, we cited to the *Davis* case as support for our position that the Courts will only extend the duty of care in very limited circumstances. These limited circumstances include where the manufacturer of a vaccine allegedly failed to advise of the risk of exposure notwithstanding vaccination,[2] but not where the non-patient's injury was unrelated to the treatment of the patient.[3] In other words, the Court of Appeals has extended the duty of care beyond the physician-patient relationship only in those cases where the plaintiff's injury was the very type of injury sought to be prevented by, or was the direct result of, the defendant's treatment. We were thus able to distinguish our case because the plaintiff's injury – a fractured ankle – was not the type sought to be prevented by a drain suture. Importantly, the plaintiff herself also voluntarily agreed to hold the flashlight and was not obliged to do so.

In moving for summary judgment, we argued that the defendant Hospital and physician did not owe a duty to the plaintiff as there was no physician-patient relationship.

We also argued that the plaintiff's injury was unforeseeable, as affirmed by our expert otolaryngologist. The conduct at issue here – a physician's asking a patient's wife to hold a flashlight after the lights dimmed so that he could complete the task of placing a suture – would not reasonably have been perceived as posing any risk to the plaintiff whatsoever. The request was not medical in nature and it was our position that it was reasonable for the physician to request assistance

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1. 26 N.Y.3d 563 (2015).
2. *See, Tenuto v. Lederle Labs., Div. of Am. Cyanamid Co.*, 90 NY2d 606, 612 (1997)(extending the duty of care to a non-patient infected by polio when the claim was that the defendants failed to advise the infant patient's parents of the risk of exposure to the polio virus following the infant's vaccination).
3. *See, McNulty v. City of New York*, 100 N.Y.2d 227 (2003).

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under the circumstances. Critically, it was unforeseeable that holding a flashlight would cause the plaintiff to faint and the ankle fracture was not a direct consequence of the suturing.

The plaintiff's attorney raised a number of arguments in opposition that we successfully dealt with in Reply. These arguments included that the injury must have been foreseeable because it occurred, that it was negligent to permit the lights in the recovery room to dim, and that the physician was negligent in not asking that the lights be raised. We argued that these new claims should not be considered. In addition, we reiterated that the Appellate Division, First Department has previously held that a physician's duty of care to a patient may not be extended to that patient's family members.[4]

In granting our motion for summary judgment, Justice George Silver held that this was a claim sounding in ordinary negligence and not medical negligence, and that the plaintiff's attorney improperly raised new claims for the first time in opposition to our summary judgment motion. Most importantly, the Court acknowledged the reluctance to extend a physician's duty of care beyond the traditional physician-patient relationship and adopted the case law included in our motion papers. Justice Silver noted that even if the duty were extended beyond the physician-patient relationship in this case, liability still could not be imposed because the events here were unforeseeable, since asking a person to hold a flashlight could not be reasonably perceived as posing a risk of harm. Moreover, although plaintiff asked the court to find a question of fact as to the foreseeability of the injury, she failed to support her argument with any expert affidavit. The case was dismissed in its entirety.

Critical to the outcome in our case was that we were able to elicit favorable deposition testimony that the plaintiff voluntarily agreed to hold the flashlight. Moreover, this case is an illustration that notwithstanding the concern that followed the *Davis* decision, the courts remain reluctant to extend a physician's duty of care to non-patients when the injury is not the specific type sought to be prevented by the defendant's treatment and the injury was unforeseeable.

Barbara D. Goldberg is a Partner and Head of the Firm's Appellate Practice Group. Ms. Goldberg is well known for her appellate expertise in high exposure and complex cases and has handled hundreds of significant motions and appeals in State and Federal Courts. She is noted for several important decisions in the areas of medical malpractice, negligence, workers' compensation and labor law.

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4. *See, Urciuoli v. Lawrence Hospital Center,* 89 A.D.3d 533 (1st Dept. 2011)(holding that duty of care may not be extended to family member who fell from a chair while watching physician treat her mother in a hospital). The *Urciuoli* case was very similar to the current case in that the plaintiff remained in the room to comfort her mother, at the physician's request, and became dizzy. She was assisted to a chair by a nurse but within seconds slid off the chair and sustained spinal injuries. The First Department here held that there was no duty established simply by assisting the plaintiff into a chair as this did not constitute medical treatment and that her expectation that the hospital staff would prevent her from falling was unreasonable under the circumstances. In addition, and of particular relevance here, the Appellate Division rejected the plaintiff's argument that even if no medical duty arose, she had stated a valid claim in ordinary negligence because her injuries were caused by the defendant doctor's request that she "assist" him by comforting her mother while her mother was being treated.

New York Hospitals Now Required to Screen for Substance Use Disorder

By: Daniel L. Freidlin and Michelle A. Frankel

Substance use disorder (SUD) continues to be a growing public health concern, with deaths from drug overdose rising annually. The Centers for Disease Control and Prevention estimate that approximately 115 individuals die from opioid overdose daily.[1] In New York alone, it is estimated that 1.4 million individuals suffer from SUD.[2] Heroin overdose has been found to be the leading cause of accidental death in New York.[3] This public health crisis is not limited to adults. A 2016 National Survey on Drug Use and Health estimated that approximately 891,000 adolescents aged 12-17 misused opioids in the prior year.[4] Earlier this year, the New York State Department of Health (DOH) proposed a new law requiring that hospitals adopt policies and procedures to "identify, assess, and refer"[5] patients with SUD. The new requirements, which became effective on July 11, 2018, can be found within the text of New York State Public Health Law §2803-u, 10 NYCRR 405.9 and 10 NYCRR 407(b)(6).

Under the law, hospitals are now required to develop, maintain and disseminate written policies and procedures for identification, assessment and referral of individuals with a documented SUD or who appear to be at risk for SUD. The identification of these patients must take place not only at the initial evaluation, but throughout the hospital admission up to and including during discharge. All health care providers that are involved in the patient's care during the hospital admission can be deemed to be responsible for evaluating patients for SUD. Specifically, the statute mandates that "hospitals establish and implement training…for all individuals licensed or certified pursuant to title eight of the education law who provide direct patient care regarding [the identification and assessment of SUD]." As such, the law can be read to mandate that all health care providers from the triage nurse, emergency department physician, physician assistants, attending physicians, staff nurses and others that provide "direct patient care" must be trained to identify at risk patients. Once a patient is found to suffer from SUD or be at risk for SUD, the health care provider must inform the patient of treatment services available at either the hospital or at another facility. This includes the dissemination of written materials to educate the patient about SUD and its treatment.

The proposed text of the law was first published in the January 10, 2018 DOH Register and public comments were accepted prior to the final text of the statute being finalized. The proposed law was passed without change on June 22, 2018. Review of the comments submitted and the DOH's responses provide some insight into the scope of the assessment required and the responsibilities of the hospital under the new law. Specifically, Greater New York Hospital Association (GNYHA) submitted three comments for consideration.

Once a patient is found to suffer from SUD or be at risk for SUD, the health care provider must inform the patient of treatment services available at either the hospital or at another facility.

First, GNYHA recommended that hospitals be provided "flexibility in determining appropriate approaches to identify and assess individuals for substance use disorders."[6] GNYHA suggested that while hospitals have used assessment methods such as Screening, Brief Intervention and Referral to Treatment in the past, this is not always reimbursed by Medicaid. In response, the DOH noted that hospitals "have the flexibility to use any other available, evidence based approach" to assess their patients for SUD.[7]

GNYHA further suggested that a health care provider's review or consultation with the State's prescription monitoring program database should serve as an acceptable method of identifying and assessing patients for SUD. The DOH responded that

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1. https://www.cdc.gov/drugoverdose/epidemic/index.html.
2. https://docs.dos.ny.gov/info/register/2018/jan10/pdf/rulemaking.pdf.
3. *Id.*
4. Results available at https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm#opioid1.
5. DOH Notice of Adoption of Hospital Policies and Procedures for Individuals with Substance Use Disorder. Available at https://docs.dos.ny.gov/info/register/2018/july11/rulemaking.pdf?
6. *Id.*
7. *Id.*

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while the prescription monitoring program database may contain information that suggests SUD, in most cases it will be necessary to consider additional information as part of the evidence-based assessment required under the regulations. The DOH's response to this comment suggests that relying solely on the information contained within the prescription monitoring program database will not be sufficient to satisfy the requirements under the law.

Finally, GNYHA recommended that hospitals be permitted to rely on health homes, community based organizations providing care management services, and other care coordination entities to help connect providers of SUD treatment services to eligible patients after discharge.

The DOH responded that a referral to such an entity may satisfy the statutory requirement if the facility selected provides the required treatment services.

The legislative objective and its long-term goal of these statutory amendments include addressing the prevalence of substance use, including opioids and heroin, which has become a public health crisis throughout New York communities.[8] The law imposes new requirements on hospitals for establishing and implementing protocols to ensure that health care providers assess patients for SUD. It is recommended that hospitals and their staff familiarize themselves with the requirements under the new law to ensure compliance.

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8. https://docs.dos.ny.gov/info/register/2018/jan10/pdf/rulemaking.pdf.

MCB CASE RESULTS

June 2018: Senior trial partner Anthony M. Sola, assisted by partner Thomas Kroczynski, associate Kerona Samuels and paralegal Marilyn Weiss, obtained a defense verdict in a breast cancer case in Supreme Court, Queens County. Plaintiff, a then 42-year-old married, working mother of three, claimed our radiologist misread a mammogram. Seventeen months later she was diagnosed with a lobular breast cancer, Stage IIIC, with a significantly shortened life expectancy. The tumor was 8 x 8 cms and had spread to ten lymph nodes. She had undergone bilateral mastectomies, and chemo & radiation therapy. Our defense was that her cancer was an aggressive, inflammatory cancer with an exceptionally fast doubling time and would have been too small to be detectable on mammography at the time. Our pre-trial preparation of plaintiff's experts turned up crucial prior testimony completely contradicting their testimony at trial. Additionally, we found one of the experts had been convicted of fraudulent billing in a Federal case and spent 6 months in jail! The result was a unanimous defendant's verdict.

June 2018: Of Counsel Christopher Terzian, Secures a Defense Verdict in Supreme Court, Westchester County, before Judge William Giacomo: Plaintiff, a then 52-year-old woman with spondylolisthesis at L4 - L5, claimed that a pedicle screw was negligently placed during stabilization surgery performed by our client surgeon. Our client surgeon operated to stabilize the area, remove disc and bone, to relieve pressure on the L4 and L5 nerve roots bilaterally (he performed a two-level decompressive laminectomy with spinal fusion from L4 to S1). One of the pedicle screws was misplaced. Plaintiff claimed this injured the right L5 nerve root, and resulted in three subsequent surgeries. In actuality, the misplaced right L5 pedicle screw was not irritating or impinging the right L5 nerve root, and her complaints were related to continued nerve compression bilaterally. Plaintiff's expert admitted at trial that pedicle screw misplacement is a known and accepted risk of the surgery, particularly when all safeguards to ensure proper pedicle screw placement were undertaken, as in this case. In addition to a neurosurgeon, a neurophysiology expert testified for the defense, that based on the intraoperative neurophysiologic monitoring, there was no indication that the screw was misplaced or that it was touching the L5 nerve root. This was persuasive proof to the jury that there was no injury from the screw misplacement. Further, our client testified that when he learned of the misplaced pedicle screw from a postoperative CT scan, he had the choice of either leaving the screw alone or replacing it with another screw. Based on this testimony, the judge gave an "error in judgment" charge. The jury returned a defense verdict.

July 2018: MCB Motion for Summary Judgment Victory in Dental Malpractice Case: Senior Partner Jeffrey Shor and Associate Kevin Marks successfully moved for summary judgment before Honorable Justice Joan A. Madden in the New York County Supreme Court in a case alleging failure to timely diagnose and treat a benign but aggressive neoplasm of the right mandible. Plaintiff argued that our client dental office failed to appreciate a neoplastic lesion on plaintiff's radiographs for the period of one year, delaying her diagnosis and resulting in a partial mandibulectomy and reconstruction with loss of teeth, nerve damage, and permanent difficulty speaking and eating. In MCB's motion, written by Kevin Marks, we were able to establish through our oral and maxillofacial surgery expert that plaintiff's condition already required a significantly similar resection and reconstruction procedure prior to the alleged delay. The Court agreed with MCB's argument that plaintiff had failed to submit any evidence that the neoplasm had grown during that year so as to require a more expansive resection procedure or that any specific injury could have prevented by an earlier surgery. Accordingly, the Court found that our client dental office's alleged delay was not a proximate cause of plaintiff's injuries, and the matter was dismissed with prejudice.

July 2018: MCB Motion for Summary Judgment Victory: Senior Trial Partner Bruce G. Habian and Senior Associate Jeffrey Stupak's Motion for Summary Judgment was granted dismissing the defendant Hospital from an action in Supreme Court, Albany County. Plaintiff alleged the failure to properly treat retinopathy of prematurity (ROP) resulted in bilateral blindness of a premature infant. The infant was initially followed by the co-defendant pediatric ophthalmologist who performed laser surgery to prevent retinal detachment. Following surgery, the infant was transferred to the defendant Hospital. Upon admission, bilateral retina detachments were diagnosed. Retinal reattachment surgery was performed 10 days after transfer, but the infant remained completely blind. The co-defendant argued that if surgery was performed within 48-72 hours of transfer, the infant's vision may have been salvaged. We argued that upon transfer, the damage was already done and time was not of the essence. The Court granted the motion because the opposition did not establish an industry practice requiring surgery within 48-72 hours of retinal detachment and there was no evidence the defendants deviated from the appropriate standard of care.

What's New at MCB?

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MCB Featured in Legal Leaders in the Law in June 2018

Martin Clearwater & Bell LLP was featured in New York's Leaders in the Law 2018 as published in *New York Magazine*. *New York's Leading Lawyers*, presented by Leaders in the Law, is a special section that highlights the achievements of the tristate area's exceptional practitioners.

5 Partners from Martin Clearwater & Bell LLP Were Recognized in *The Best Lawyers in America*© 2019

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Thomas A. Mobilia Named to New York State Bar Committee Leadership Positions

In June of 2018, Thomas A. Mobilia was named Co-Chair of the NYSBA Healthcare Professionals Committee and Member of Health Law Section's Executive Committee.

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