MARTIN CLEARWATER & BELL LLP

DEFENSE PRACTICE UPDATE

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MEDICAL INDEMNITY FUND DEVELOPMENTS: OPEN QUESTIONS AND ISSUES

BY: BARBARA D. GOLDBERG

The New York State Medical Indemnity Fund became operational on October 1, 2011. Since that time, the New York State Commissioner of Health, in consultation with the Superintendent of Insurance, has promulgated regulations which further shape the structure within which the Fund will operate. The new regulations appear as Subpart 69-10 to NYCRR Part 69, Title 10.

NEW REGULATIONS

The regulations, effective December 14, 2011, include critical definitions such as "birth-related neurological injury" and "qualifying health care costs" for purposes of coverage. The regulations also explain the application process for enrollment in the Fund; what qualifying health care costs will require prior approval; what the claims submission process and review process will be; and how and when the required actuarial calculations will be done.

The "Summary of Express Terms" accompanying the regulations explains that "qualifying health care costs" are defined as broadly as defined by the statute, and that prior approval will be required only for very costly items, items that involve major construction, and/or out of the ordinary expenses. In addition, the Summary indicates that the application process has been developed to be as streamlined as possible; that there will be prompt decisions on reviews of claim denials and requests for prior approval; and that an expedited review procedure has been developed for urgent situations.

Presumably, a broad definition of "qualifying health care costs" and the existence of a prompt review mechanism will alleviate the concerns of plaintiffs' counsel that their clients will be subject to less than optimum treatment because of bureaucratic delays. It seems clear from the regulations that prior approval will not be required for routine items of care such as medical treatment, prescription drugs and therapies, but only for such unusual expenses as an environmental modification or "Emod" to the plaintiff's residence, vehicle modifications, custom made

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equipment, experimental treatments or procedures and the like.

The definition of "birth-related neurological injury" in the regulations is the same as that in the statute: "an injury to the brain or spinal cord of a live infant caused by the deprivation of oxygen or mechanical injury that occurred in the course of labor, delivery or resuscitation or by other medical services provided or not provided during delivery admission that rendered the infant with a permanent and substantial motor impairment or with a developmental disability..."[1] "Delivery admission," in turn, is defined as "a hospital admission for the specific purpose of giving birth."[2] Significantly, however, the regulations also expand the definition of "hospital" to include a birthing center operating as a diagnostic and treatment center.[3] Thus, claims against midwives and birthing centers may be included in the Fund provided other qualifying criteria are satisfied.

For purposes of enrollment in the Fund, the regulations confirm that an application may be submitted by a "defendant in a medical malpractice claim or action that results in a court-approved settlement or judgment... finding that the plaintiff sustained a 'birth-related neurological injury.'"[4] Thus, if the plaintiff's attorney fails to take the necessary steps to enroll an infant in the Fund, defense counsel may do so.

In addition, the regulations provide for prompt notification to the parties once an infant has been accepted into the Fund: "[u]pon determining that the court-approved settlement or the judgment deems or finds the plaintiff or claimant to have sustained a birth-related neurological injury, the Fund Administrator shall enroll the qualified plaintiff within 15 business days of such determination and provide written notification of enrollment to the qualified plaintiff or a person who is authorized to act on a qualified plaintiff's behalf... and to the defendant."[5]

At a minimum, therefore, it appears that defendants have a strong argument, based on this definition, that an avulsion injury qualifies as "an injury to the... spinal cord of a live infant caused by... mechanical injury as contemplated by Public Health Law § 2999-h(1).

[1] § 69-10.1(c).
[2] § 69-10.1(h).
[3] § 69-10.1(q).
[4] § 69-10.2(a)(3).
[5] § 69-10.2(f).
[6] O'Leary, Shoulder Dystocia and Birth Injury, 3rd ed., Humana Press 2009 (emphasis added).

OPEN QUESTIONS AND ISSUES

Notwithstanding the promulgation of these regulations and the fact that many cases have now been settled under the Fund, many questions still remain. These include the issues of what injuries meet the definition of "birth-related neurological injury" as set forth in the statute and regulation and, how a settlement should be allocated between Fund and non-Fund items of damages. Certain of these questions were addressed by Hon. Douglas E. McKeon of the Supreme Court, Bronx County at a program sponsored by the Association for Healthcare Risk Managers of New York, Inc. (AHRM) in December 2011.

How flexible is the concept of "birth-related neurological injury?"

A recurring question, from the time of the Fund's creation, is whether Erbs Palsy qualifies as a birth-related neurological injury. At the AHRM program, Justice McKeon indicated that he could make an argument for either side as to whether a typical Erbs Palsy case should be included in the Fund. He also stated, however, that he believes those cases involving an avulsion of the brachial plexus should qualify. As support for this position, he cited the following definition:

> "Obstetrical brachial plexus palsy results from iatrogenic (physician induced) strong traction or stretch injury to the cervical roots C5-8 and T1... ***Avulsion is the most severe type, where the nerve is torn from the spinal cord...***".[6]

At a minimum, therefore, it appears that defendants have a strong argument, based on this definition, that an avulsion injury qualifies as "an injury to the... spinal cord of a live infant caused by... mechanical injury" as contemplated by Public Health Law § 2999-h(1).

More problematic are injuries attributable to care during the pre-natal period, such as a failure to diagnose gestational diabetes or preeclampsia which results in neurological impairment to an infant. Under a strict interpretation of the statutory definition, such injuries would likely not qualify as "occurring in the course of

labor, delivery or resuscitation or by other medical services provided or not provided during delivery admission." On the other hand, if the plaintiff alleged departures from accepted practice resulting in injury during both the prenatal period and the labor and delivery, the infant would likely be eligible for the Fund. Justice McKeon indicated at the AHRM program that he favors an expansive interpretation of what constitutes a "qualifying injury," and that in a case involving "concurrent" causes of injury attributable to both the prenatal period and the labor and delivery, he believes that the child should go into the Fund.

Indeed, except in an extraordinary case where a determination has been made (perhaps at a *Frye* hearing) that a child's injury is entirely unrelated to the birth admission, Justice McKeon believes that the court is *obligated* to certify a child as eligible for the Fund. He considers it unlikely that the Fund Administrator would second-guess the court's determination.

We have also been advised that another Supreme Court justice has recommended that the statutory definition should be expanded to include injuries occurring during the prenatal period. Whether this recommendation will be implemented remains to be seen, but as indicated above, if it can be established that an infant's injury is attributable at least in part to the deprivation of oxygen or mechanical injury during the delivery admission, then the infant should qualify for the Fund.

How should a settlement be allocated?

In *Mendez v. The New York and Presbyterian Hospital*, 2011 NY Slip Op 21407, which involved a catastrophically injured child who would require future custodial care for the rest of his life, Justice McKeon approved a 50-50 allocation of a $5,500,000 settlement between Fund and non-Fund items of damages (i.e., pain and suffering and lost earnings). Prior to doing so, he reviewed the prevailing appellate case law regarding sustained awards for custodial care. While awards for future custodial care and the like frequently represented much more than 50% of a total sustained award, Justice McKeon indicated in his remarks at the AHRM program that some "adjustment" for settlement of Fund cases is proper, since enrollment in the Fund reduces the amount of ready cash available to the plaintiff. He believes that at least in cases where future custodial care is involved, a 50-50 allocation is appropriate.

Indeed, except in an extraordinary case where a determination has been made (perhaps at a Frye hearing) that a child's injury is entirely unrelated to the birth admission, Justice McKeon believes that the court is obligated to certify a child as eligible for the Fund.

On the other hand, in a case where most of the medical expenses were incurred in the past, a different allocation might be called for. For example, Justice McKeon suggested that in an Erbs Palsy case involving an avulsion, an 80-20 allocation, with 20% of the settlement allocated to Fund, might be appropriate.

Ideally, cases involving the Fund should be settled in the same manner as before the Fund was created: the parties should agree on the settlement amount, and then make an allocation between Fund and non-Fund damages. The underlying assumption is that if for any reason the infant did not qualify for enrollment in the Fund, or enrollment ceased because the Fund's estimated liabilities reached or exceeded 80% of its assets, the defendants and/or their insurers would then pay the settlement in full. This, of course, is not a matter of concern in cases involving a hospital defendant with extensive layers of coverage, where the hospital would be able to pay the settlement regardless of whether the infant was accepted into the Fund.

More problematic are cases where there is limited coverage – as, for example, a case involving a small-self insured hospital or a physician with $1 million to $3 million in coverage and a catastrophically-injured infant plaintiff. In such a case the defendant may be willing to agree to a settlement number, on paper, that

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is in excess of the coverage, on the theory that the allocation of a portion of the settlement to the Fund will mean that the actual payment to be made by the defendant will be within the coverage. Such a settlement, of course, poses a risk to the defendant if the infant is rejected by the Fund administrator (which is probably unlikely) or if enrollment closes. Justice McKeon has suggested that one approach to protecting the defendant in such a scenario might be for the parties to enter into a "settlement agreement" which would be contingent on, and not take effect until, the infant compromise order was signed. In such a case, the compromise order would not be signed unless and until the child was accepted into the Fund, thereby eliminating the risk that the defendant would be bound to a settlement in excess of policy limits. Also, some judges have apparently permitted the inclusion of "escape clauses" in settlement agreements whereby the settlement is contingent upon the infant's acceptance into the Fund.

Thus, this type of settlement appears to be feasible, and, accordingly, a case with $3 million in coverage could potentially settle on paper for $4.5 million with a 50-50 allocation. Once the the compromise order was signed and the infant was accepted into the Fund, the amount that the defendant's insurer would actually have to pay, inclusive of the attorney's fee on that portion of the settlement attributed to the Fund, would be $2,550,000. (The attorney's fee is allotted proportionately between Fund and non-Fund items and the defendant is responsible for paying the fee on the Fund items).

In cases where a defendant is willing to pay a specific amount, as, for example, $250,000, we have been able to determine the particular settlement amount which, based on the allocation percentages and the attorney's fee on the Fund damages, will result in the desired payment. For example, if the defendant wanted to make a total payment of $250,000, the settlement amount, based on a 50-50 allocation, would be $390,000 on paper. The 50-50 allocation ($195,000 attributable to Fund and non-Fund items of damages) results in a total payment of $250,000 because the attorney's fee on the Fund damages, under the sliding scale, would be $55,000. The defendant would pay the $195,000 allocated to the non-Fund damages, together with the $55,000 attorney's fee on the Fund damages.

DOES THE FUND APPLY IN FEDERAL COURT?

The issue of whether the Fund applies in federal court is significant in cases where a physician or hospital is named as a defendant together with a clinic that is federally funded, requiring that suit be brought under the Federal Tort Claims Act (FTCA). The issue of whether the Fund applies in federal court is also important in diversity cases involving birth-related neurological injuries.

In what appears to be the first federal court decision to address the issue, the United States District Court for the Southern District of New York held in Jacobs v. United States, 08 Civ. 8061, that the Fund is a matter of state substantive law and applies in an FTCA case. The plaintiffs in Jacobs alleged that the defendants provided inadequate management of the mother's high-risk labor at a state hospital center, and that as a result, the infant plaintiff suffered severe bradycardia and related metabolic acidosis, resulting in permanent neurological injuries. In connection with the settlement of the action, Magistrate Judge Kevin Nathaniel Fox directed the parties to brief the issue of whether the action was subject to the Fund. In a Memorandum and Order dated February 22, 2012, Judge Fox accepted the state defendants' arguments that the Legislature intended the Fund to be a substantive law, as it affects the rights and obligations of parties, and that "[f]ederal case law requires the application of a state statute regarding the payment of damages in a medical malpractice case because such statutes are substantive law." Since there was no question that the infant plaintiff had sustained a birth-related neurological injury, and no compromise order had been signed as of April 1, 2011, Judge Fox held that the plaintiff was eligible for enrollment in the Fund.

Judge Fox also took the unusual step of appointing a guardian for the infant plaintiff, concluding that in light of his determination that the Fund applied and considering the nature of the claims asserted, there was a potential conflict of interest between the plaintiff mother and the infant plaintiff.

Presumably, other federal judges will likewise conclude that, assuming an infant has sustained a "birth-related neurological injury" and is otherwise

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eligible for enrollment, the Fund applies to FTCA and diversity cases.

Furthermore, it is consistent with the intent and purpose of the Fund legislation to conclude that the Fund applies in cases brought in federal court where a state hospital or a physician who is not a federal employee is a party. The purpose of the Fund is "to provide a funding source for future health care costs associated with birth related neurological injuries, in order to reduce premium costs for medical malpractice insurance coverage."[7] As noted in *Mendez,* "the creation of an obstetrical fund was an obvious vehicle by which to achieve the Governor's dual objective of reducing both Medicaid costs and medical malpractice premiums while, on a human level, providing a lifetime of guaranteed care, geared to obstetrical mishap victims... ."

The objectives of providing a lifetime of guaranteed care to neurologically impaired infants, while at the same time reducing premium costs and medical malpractice costs to hospitals, apply equally regardless of whether an action is brought in state court or in federal court. Moreover, there is a strong policy argument that the defendants in a case brought in federal court should not be treated differently than otherwise similarly situated defendants in a state court action. Such an argument was accepted many years ago by the Federal District Court for the Southern District of New York in *Alisandrelli v. Kenwood*,[8] which held that CPLR Articles 50-A and 50-B, which were intended to lower insurance premiums and the costs of satisfying a judgment by providing for the periodic payment of future damages in excess of $250,000, applied in diversity actions. The District Court concluded that "[b]ecause failure to apply the state statute would substantially affect the enforcement of a state right, invite forum shopping and the inequitable administration of the law, and undercut the strong state interest in moderating insurance premiums whle assuring fair and adequate compensation to injured persons, the state law will be applied." [9] The same considerations clearly apply to the Fund.

IS THE FUND WORKING?

While, as noted, many questions concerning the Fund remain unanswered at this still early stage, it was Justice McKeon's view at the AHRM program that the Fund is working. He indicated that most attorneys with whom he has settled cases believe that the Fund is being well-managed. Since the Fund became operational, applications for enrollment have been processed expeditiously, and a response is typically received within a few days after an application is submitted, which facilitates settlement.[10] With respect to the issue of whether enrollment in the Fund will somehow result in less than optimal care to an infant, Justice McKeon indicated that in extraordinary cases, he would be disposed to setting aside some portion of a settlement amount in a "medical trust" to cover the costs of "cutting edge" treatments that might not be paid by the Fund or a private insurance company. More importantly, he emphasized that once a child is accepted for enrollment, the child is "in the Fund for all purposes," and the Fund will pay for all qualifying health care costs incurred over the child's lifetime, even those unrelated to the original injury. For example, if a child developed cancer after enrollment in the Fund, the Fund would cover the costs of the cancer treatment as well as the original injury. Furthermore, the Fund eliminates the necessity for a Special Needs Trust to enable the plaintiff to receive settlement cash while still remaining eligible for Medicaid, and the

7 P.H.L. § 2999-g.

8 724 F. Supp. 235 (S.D.N.Y. 1989).

9 724 F. Supp. at 242.

10 The application form is available on the Department of Financial Services website at http://www.dfs.ny.gov/insurance/mif_indx.htm.

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DEFENSE OF A BREAST CA

BY: BRUCE G. HABIAN

There are unique considerations referable to defending a breast cancer case. This article pertains to risk management education, pretrial analysis of issues, and the substance of trial proceedings. In clinical practice, a competent documented treatment plan by primary care physicians (General Practitioners, Internists or OB/GYN), should utilize the services of surgeons, radiologists and pathologists as consultants. The defense of a breast cancer malpractice case should follow the same logic.

RISK FACTORS FOR BREAST CANCER

The single leading risk factor for the development of breast cancer is the fact of being a woman; seventy-five (75%) of all breast cancers occur in women who have no other known risk factors. Recognized predisposing risk factors include: (a) a previous personal history of breast cancer; (b) family history of breast cancer; (c) increasing age; (d) North America or northern Europe country of birth; (e) upper socioeconomic class; (f) age above thirty (30) at first childbirth; (g) early menarche; (h) late menopause; (i) history of fibrocystic disease; and (j) history of ovarian or endometrial cancer (also history of chest radiation).

CLINICAL CONSIDERATIONS

The most common clinical complaints relate to: (a) breast lump/thickening; (b) breast pain; and (c) nipple discharge. The majority of such complaints are unrelated to breast cancer particularly in women under the age of fifty. It is a commonly accepted clinical standard to allow one or two months to elapse and then reevaluate the patient in situations where either a definite abnormality or cancer is not obvious, to be sure that the mass, thickening, or pain is persistently present. Patients with a breast complaint are therefore usually advised to have a mammogram.

BREAST CANCER PATHOLOGY

Histological aspects of breast cancer are frequently confusing; breast cancer develops usually in the actual milk making gland (lobule) or develops in the conduit (duct) intended to carry the milk to the nipple. If the cancer is in the milk making gland it is termed *lobular carcinoma*; if it is in the conduit it is termed *ductal carcinoma*. If the cancer has not grown sufficiently to invade the walls of the lobule or the duct, the cancer is known as "in situ" (in place); this is considered an extremely early pathology. If the cancer has invaded the containing walls of the lobule or the duct, it is then known as invasive lobular carcinoma or invasive ductal carcinoma. The generic expression "breast cancer", used in the lay media most often refers to invasive ductal cancer which comprises approximately seventy percent (70%) of all breast cancers.

THE IMPORTANCE OF MAMMOGRAMS

The mammogram is the best non-invasive diagnostic test available, although it lacks diagnostic accuracy. While mammography can ultimately diagnose as much as seventy percent to eighty percent (70%-80%) of breast cancers, such accuracy is only obtained by offering a suggestion of possible breast cancer, far more often than is actually true. Radiologists tend to "over read" the possibility of breast cancer in an effort to avoid a failure of diagnosing breast cancer. The physical findings in the breast should not be ignored merely because the mammogram is considered normal -- mammograms will miss approximately ten percent (10%) to fifteen percent (15%) of breast cancers. If the original clinical abnormality persists, the patient should be referred to a surgeon; if the abnormality is considered significant, a breast biopsy should be performed. The term breast biopsy is a general term and may variably refer to

removing a few cells through aspiration with a needle, or to performing an open operative procedure with anesthesia, at which time either part or all of the abnormality is removed. Such tissue removed must be examined by a pathologist to establish a definitive diagnosis.

Screening and diagnostic mammograms

Screening tests are performed on asymptomatic women without clinical findings; medio-lateral oblique and cranio-caudal views of each breast are generally obtained. Diagnostic mammograms relate to patients with clinical findings or those with suspected screening abnormalities that require complete diagnostic imaging. Additional views, including magnified images, are obtained as needed. Correlation of physical findings with a mammographic image is mandatory. Spot compression views using magnification techniques are utilized. Skin markers are used (particularly important with a patient with prior surgical experience), as a surgical scar may mimic a malignant mammographic finding.

Mammograms and biopsies

Asymptomatic women should not undergo surgical biopsy based upon a lesion detected solely per a screening mammogram. Diagnostic mammography must be called into play to demonstrate that many screening abnormalities represent merely super-imposition of normal breast structures, thus eliminating the need for further intervention such as surgical biopsy. Ultrasound is also utilized to distinguish normal breast tissue from pathology, particularly for a patient with dense breast tissue or a possible mass on physical examination. Lesions clearly identified as cysts may be followed up with routine screening. Symptomatic cysts are cysts large enough to interfere with the mammographic examination, and can be aspirated or injected with air in an attempt to reduce the incidence of cyst recurrence. Recent studies have advocated for sonography as well as MRI studies to be undertaken for dense breast patients.

TECHNIQUE OF BREAST BIOPSIES

Breast biopsy is removal of breast tissue or other material such as fluid for further examination under microscopic technique. These include:

A. Fluid cytology – fluid is obtained directly from the nipple or from breast aspiration.

B. Fine needle aspiration – a relatively small caliber needle attached to a syringe is inserted into the breast and cells are removed.

C. Core needle – removes a small plug of solid tissue.

D. Incisional biopsies -- made into the abnormality rather than removal of the entire abnormality.

E. Excisional – the entire abnormality is removed; usually refers to smaller lumps or other abnormalities.

F. Wire directed – lesions detected by mammograms or ultrasound that are nonpalpable; the radiologist immediately prior to the operative procedure inserts a needle into the breast which points to the abnormality. This is then confirmed by mammography or ultrasonogram and the wire is threaded through the needle and allowed to remain in the breast to assist the surgeon removing the intended abnormality.

G. Stereotactic fine needle aspiration – refers to a computer directed insertion of a fine needle into the patient's breast under mammogram direction. Usually this will eliminate the need for an operative procedure to identify a nonpalpable abnormality.

H. Galactography – contrast dye is inserted into a milk duct and the nipple to further define with x-ray the location of an abnormality producing a nipple discharge.

STAGING OF BREAST CANCER

Staging is a classification of cancers in such a way that breast cancers can be compared to each other and therefore their response to various treatment modalities can be evaluated over a designated period of time.

Anatomic classifications are provided for the tumor itself (tumor = T); the regional lymph nodes (nodes = N); and the presence or absence of distant metastasis (metastasis = M). The system is known as TNM System. The staging of the tumor, nodes and distant metastasis are then combined in a variety of combinations to yield an overall stage grouping for that patient. This form of classification is accepted and approved by the American Joint Committee on Cancer, the American Cancer Society, and the American College of Surgeons, Commission on Cancer.

There are other prognostic factors in use for purposes of assessing the severity of the illness; these include hormone binding status (estrogen and progesterone receptiveness); DNA flow cytometry; S-phase fraction [these rather sophisticated subjects concern themselves with growth and metastasis of the primary tumor and cell division per DNA parameters – proliferative status and mitosis].

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TREATMENT

The treatment of breast cancer when newly diagnosed is based upon the extent and severity of the disease, both within the breast and elsewhere in the body. Three (3) modalities currently used to treat breast cancer are: (a) surgical procedures; (b) radiation therapy; and (c) drugs specifically directed at the cancer cells (chemotherapy).

Surgical treatment includes radical mastectomy, modified radical mastectomy, and preserving of breast tissue per lumpectomy. Radiation is generally not used in primary breast cancer treatment if the patient has had a mastectomy; however, it is useful in gaining regional control to guard against local recurrence of the disease.

Chemotherapy is primarily of two (2) types; mild medications such as Tamoxifen, utilized in patients less threatened by their illness and used more exclusively in post-menopausal women. Stronger medications such as cytoxic chemotherapy, most often used in pre-menopausal women and to a lesser extent in post-menopausal women. Commonly used medications are Cytoxan, Methotrexate, Fluorouracil and Adriamycin.

GROWTH OF THE PRIMARY TUMOR

Concerning the issue of causation (how, if at all, a delay in diagnosis affected the patient's prognosis), the case must be analyzed for spread of the disease relative to the time of diagnosis. The size of the primary lesion over time, and the cellular make-up must be analyzed by oncology expert opinion.

In determining the size of the tumor during the period of claimed failure to diagnose, the case must be analyzed as to whether a five (5) year survival period was affected. Also, did lymph node involvement, and metastasis occur – early - before the tumor was diagnosable?

Growth rates of the tumor relate to pathologic variety, differentiation, origin of organ, patient immune system, and response to various modalities of therapy.

The usual malignancy is diagnosed when at least 1cm. in diameter (which requires 30 doublings). Therefore, the onset of cancer is most likely years before the diagnosis has been made. Doubling time is a viable method to legally prove a change in prognosis within a reasonable medical probability. This can demonstrate a possible effect on the opportunity for survival, due to a missed or delayed diagnosis.

Doubling time (growth rate and prognosis) relates to how fast the tumor increases in cell mass, until it reaches a point of incompatibility with life. After 40 doublings (one trillion cells of tumor mass), the cellular biology of the tumor cells tend to overwhelmingly dominate the competition with normal cells for life sustaining biologic function. Doubling time is that period in time necessary for a group of cells to double in number; the measurement of a tumor is made in at least two (2) dimensions, and if possible three (3) dimensions. It has been established that in cancer, a volume of 1cm. equals one billion cells; it can be determined how many times the cells have doubled in number by measuring tumor size in two (2) different points in time during the time period concerned. With these two measurements the practitioner can also estimate the number of times the cells have doubled during the same period of time.

Differentiation is related to probable growth rate; differentiation is evaluated by microscopic study of the tissue biopsy. If the tumor cell is very similar to the normal cells in the tissues effected, and therefore considered "well differentiated" the tumor will grow at a slower rate. The more "undifferentiated or poorly differentiated" the tumor cells are, the more they are dissimilar to the normal cells in the affected area, and the more likely it is a fast growing tumor. Metastatic spread can be more rapid than the primary tumor rate of growth.

Consideration of the cell differentiation, and the size of the mass per doubling times, allows for the presumed stage of the tumor at an early date to be considered; tumor stage is an essential factor for deciding the type of treatment necessary; if in fact the tumor has progressed to an additional stage, it affects the survivability and it presents as one of the major damage elements of a cancer malpractice case.

Breast cancers grow at widely different rates; the fastest can double in size in about 30 days and the slowest can double in about 200 days – the average time is 4 months. Remember that the growth rate is not progressive and not constant.

SUMMARY

The aforementioned topics must be considered in the defense of a breast cancer malpractice case to defeat the claim of negligence. The scientific issues of cell make-up and rate of growth are of particular importance to challenge the issue of causation – namely, that the patient was made worse by a delay in diagnosis.

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The NLRB and Monitoring Employees' Use of Social Media

BY: STEVEN M. BERLIN AND DOUGLAS J. KLEIN

In the Fall 2011 *Defense Practice Update*, we reported on recent attention of the General Counsel's Office of the National Labor Relations Board ("NLRB") to employers' efforts to exercise control and implement discipline over employees' potentially undesirable, unflattering or unwanted use of social media. The takeaway was that employers need to be mindful of employees' rights protected under Section 7 of the National Labor Relations Act ("NLRA") when disciplining employees for undesirable social networking activity and implementing social media policies.

Since then, in January 2012, the NLRB's General Counsel felt compelled to speak out again, issuing a second report concerning social media ("the Second Report"). The Second Report makes clear the NLRB is increasing its oversight of employers' responses to employee social networking activity. The Second Report provides new examples for employers of what it considers overreaching when disciplining workers for undesirable social networking activity and new guidance for drafting social networking policies.

While employers, particularly in non-union workplaces, may have previously tended to limit their focus on employee communications to prohibiting things such as dissemination of confidential information or discriminatory utterances, the vast reach and potential impact of social networking has realigned the focus to potentially disparaging and embarrassing speech. Likewise, while the NLRA always provided a degree of protection for certain employee speech, the Second Report underscores that such protections must be part of this new focus on workers' social networking communications.

Section 7 of the NLRA provides both unionized and non-unionized employees with the right to "engage in concerted activities" for "mutual aid and protection" (so called "Section 7 rights"). This includes workers discussing wages, hours and other terms and conditions of employment which is concerted if part of group action or even the activity of a single individual who seeks to initiate, induce or prepare for group action.

Violations of the NLRA are known as unfair labor practices and they are filed with the NLRB. It is an unfair labor practice for a company to interfere with, restrain or coerce employees in the exercise of Section 7 rights. This can be done by simply maintaining a work rule that would reasonably tend to chill employees in the exercise of their Section 7 rights. A rule is reasonably chilling if, among other things, it either explicitly restricts Section 7 activity, employees would reasonably construe the rule to prohibit Section 7 activity or the rule has been applied to restrict employees' exercise of Section 7 rights. However, Section 7 protection is not absolute. Concerted activity or speech which is so egregious it rises to a level of abuse, humiliation or insult as judged based on the place, subject manner, nature and circumstances giving rise to the activity may not be protected.

The General Counsel found the discharge lawful because the Facebook postings involved an individual gripe, the worker had no particular audience in mind when she made the posts, the posts contained no language suggesting she sought to initiate coworkers to engage in group action and while coworkers offered sympathy, there was not any extended discussion over working conditions.

In the past, this basic framework has been used to determine if "water cooler" talk and other work related communications were protected. Now, while the reach and impact of employee social networking communications could be greater than "water cooler" talk, the NLRB General Counsel's Second Report provides new guidance on how employers can determine if such communications are protected under Section 7 and whether social media policies would tend to unlawfully chill that speech.

In one discipline case presented in the Second Report, an employee, after work on her personal Facebook account, post-

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ed negative remarks about her supervisor, whom she referred to as a "scumbag," and received several supportive responses from coworkers. Not pleased, the company suspended and ultimately fired her. In an ensuing unfair labor practice charge, the General Counsel found the employee was unlawfully discharged for a comment which was protected because it occurred outside the workplace during nonworking time, did not interrupt the work of any employee and concerned the protected subject matter of supervisory action, a condition of employment.

Certainly not all responses to employees' social networking activity are unlawful. The Second Report discusses an employee who was reprimanded by her supervisor and then updated her Facebook profile from her cell phone, during a break, with a comment which included an expletive and the name of the employer's store. Four individuals, including one of her coworkers, "liked" the update, and two others commented on it. Later, the employee commented that the employer did not appreciate its employees. Although several of the employee's friends and relatives commented on the second post, none of her coworkers did.

The employee was discharged for her postings and filed an unfair labor practice charge. The General Counsel found the discharge lawful because the Facebook postings involved an individual gripe, the worker had no particular audience in mind when she made the posts, the posts contained no language suggesting she sought to initiate coworkers to engage in group action and while coworkers offered sympathy, there was not any extended discussion over working conditions.

The Second Report also provides new guidance for employers on implementing lawful policies governing employee social media activity and makes clear that context is crucial in evaluating the validity of such policies.

The General Counsel disapproved of a policy prohibiting employees from identifying their affiliation with a company when engaging in social media activity, unless there was a legitimate business reason for doing so, because personal profile pages serve an important function in enabling employees to use online social networks to communicate with fellow workers. Yet the General Counsel approved of another policy which required employees engaging in social networking activities for personal purposes to indicate their views were their own and not those of their employer because it appeared in a section entitled

But determining appropriate policies and practices in the social-media age for monitoring and disciplining employee speech should be a renewed area of focus for employers who previously addressed these issues and a new area of focus for those who have not.

"Promotional Content" and employees could not reasonably construe the rule to apply to communications regarding their protected communications.

Similarly, the General Counsel found a policy prohibiting employees from disclosing or communicating confidential, sensitive or non-public information concerning the company on or through company property to anyone outside the company without prior approval of senior management or the law department unlawful because employees would reasonably understand this provision to prohibit them from communicating with third parties about protected Section 7 issues and the employer failed to provide context or examples of the types of information it deemed confidential, sensitive or non-public to clarify that the policy does not prohibit Section 7 activity.

By contrast, the General Counsel found acceptable a drug company's social media policy that permitted the employer to request employees confine their social networking to matters unrelated to the company to ensure compliance with securities regulations and other laws and prohibited employees from using or disclosing confidential and/or proprietary information, including personal health information about customers or patients. Although the request to confine social networking communications to matters unrelated to the company could be construed to restrict employees from exercising Section 7 rights, it could reasonably be interpreted to address compliance with security regulations. The prohibition on disclosing confidential and/or proprietary information was not overbroad consid-

PLOYEES' USE OF SOCIAL MEDIA

ering specific policy references to customers, patients and health information which would allow an employee to reasonably understand the employer's goal of protecting customers' privacy and not restricting Section 7 activity.

In another case, a social media policy prohibited discriminatory, defamatory or harassing web entries about specific employees, the work environment or work-related issues via social media. The General Counsel found the policy unlawful because the listed prohibitions, applied to discussions about work-related issues, and thus would arguably apply to protected criticisms of the employer's labor practices. However, the employer later replaced the policy with one that prohibited the use of social media to post or display comments about coworkers, supervisors or the employer that were vulgar, obscene, threatening, intimating, harassing or a violation of the employer's workplace policies against discrimination, harassment or hostility on account of age, race, religion, sex, ethnicity, nationality, disability or other protected class or status.

The General Counsel then found the amended policy lawful because it would not be reasonably construed to apply to Section 7 activity, and the rule appeared in a list of plainly egregious conduct such as violating the employer's workplace policies against discrimination, harassment or hostility on account of age, race religion, sex, ethnicity nationality, disability or other protected status.

The Second Report also suggests that limiting language alone is not enough to save a policy. In one case an employer restricted use of its confidential and/or proprietary information and directed employees to avoid identifying themselves as employees, unless there was a legitimate business need or when discussing terms and conditions of employment in an "appropriate" manner. A "savings clause" provided that the policy would not be interpreted or applied so as to interfere with employee rights to self-organize, form, join, or assist labor organizations, to bargain collectively through representatives of their choosing or to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection, or to refrain from engaging in such activities.

Despite these exceptions, the General Counsel found the rule unlawfully limited employee discussion of terms and conditions of employment to discussions conducted in an "appropriate" manner without defining what that meant. The "savings clause" was ineffective because an employee could not reasonably be expected to know if it encompassed discussions the employer deemed "inappropriate." Notably, however, an NLRB Administrative Law Judge hearing an unfair labor practice charge brought under this policy disagreed finding the policy lawful—a discrepancy which is indicative of how this area of the law will continue to be fleshed out on administrative appeal and in court.

It still remains to be seen whether the General Counsel's opinions in the Second Report, like its predecessor report, will withstand legal challenges. But determining appropriate policies and practices in the social-media age for monitoring and disciplining employee speech should be a renewed area of focus for employers who previously addressed these issues and a new area of focus for those who have not. Rules governing employee social networking activity should probably not differ from those governing other employee communications, and such communications may very well rise to the level of protected, concerted activity.

As the Second Report makes clear, employers can implement social media policies which protect against unlawful or unwanted disclosures, including disclosures which violate regulations or policies against harassment based on protected status, if appropriately contextualized, but must consider whether the policies could reasonably be construed as interfering with employees' Section 7 rights, incorporate appropriate limiting language, define key terms and provide examples of impermissible social networking conduct.

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An Introduction to Accountable Care

By: Thomas A. Mobilia

Accountable care organizations (ACOs) were recognized in the Patient Protection and Affordable Care Act (PPACA), enacted nearly two years ago. On January 1, 2012, the Centers for Medicare and Medicaid Services (CMS) began monitoring ACOs as part of PPACA's Medicare Shared Savings Program (MSSP).[1] Since PPACA's enactment, several states, including New York, have experimented with parts of the ACO model in their state Medicaid programs.[2] The impact that ACOs may have is substantial, leading one commentator to predict that "[b]y 2020, the American health insurance industry will be extinct." This article provides an introduction to ACOs and their current role in the federal Medicare and New York State's Medicaid programs.

An ACO must provide primary care services to at least 5,000 Medicare patients annually, agree to participate in MSSP for at least three years, and demonstrate shared governance that includes at least one Medicare beneficiary and proportions control of the ACO's decision-making process among its providers.

WHAT IS AN ACO?

CMS describes an ACO as a group of physicians, hospitals, and other healthcare providers, joined together voluntarily, to provide coordinated, high quality yet low cost care to Medicare patients. An ACO must provide primary care services to at least 5,000 Medicare patients annually, agree to participate in MSSP for at least three years, and demonstrate shared governance that includes at least one Medicare beneficiary and proportions control of the ACO's decision-making process among its providers.

As its hallmark, MSSP is offering shared savings to health care providers in ACOs. While those providers will continue to receive Medicare fee-for-service payments, they can also receive a share of the ACO's annual savings. To determine savings, the ACO's expenditures are compared to the total Medicare estimated expenses that ACO beneficiaries would have incurred in the absence of the ACO. If the ACO has provided those services at or above a minimum savings rate, it can receive up to sixty percent of its savings, provided it also meets certain quality of care standards in four areas: (i) patient and caregiver experience; (ii) care coordination and patient safety; (iii) preventative health; and (iv) at-risk populations.

1 42 U.S.C. § 1899 (2010).

2 Ezekiel J. Emanuel & Jeffrey B. Liebman, *The End of Health Insurance Companies*, N.Y.Times, Jan. 30, 2012, http://opinionator.blogs.nytimes.com/2012/01/30/the-end-of-health-insurance-companies/?pagemode=print.

ORGANIZATIONS

NEW YORK AND ACOS

It is clear at this juncture that the ACO model is a "dramatic change [that] will be difficult for many individuals and organizations"[3] to embrace and implement. As a result, on March 31, 2011, the New York state legislature adopted the Accountable Care Organization Demonstration Program to experiment with the ACO model.[4] This five-year program aims to "test the ability of accountable care organizations to assume a role in delivering an array of health care services, from primary and preventative care through acute inpatient hospital and post-hospital care."[5] Pursuant to the legislation, the Commissioner of the New York Department of Health must approve seven ACOs by 2015.

The guidelines for ACOs under this program are compatible with those of the MSSP, but are not identical. For example, under MSSP, an ACO must have 5,000 Medicare beneficiaries, while in New York, beneficiaries can also be enrollees of third-party payers. In addition, ACOs formed under New York's ACO Demonstration Program are not limited to Medicare's fee-for-service system and can establish alternative payment methodologies with third-party payers. Lastly, New York's ACOs are permitted to depart from the MSSP's shared savings model and negotiate their own compensation arrangements with third-party payers.

Despite the ACO Demonstration Program legislation, ACOs are not yet a part of New York's Medicaid program, and their prospective role in Medicaid remains unclear. In New York, as in other states, healthcare providers have already grouped together in organizations similar to ACOs with the goal of providing collaborative and cost effective care to Medicaid patients. New York's Medicaid Health Homes program, for example, extends financial incentives to groups of providers offering coordinated health care to Medicaid patients with long-term, chronic conditions.[6] Consequently, the potential for ACOs being embraced fully by New York's Medicaid program will likely depend on the success of their federal counterparts, the interest of New York's healthcare providers, and public support. Time will tell whether ACOs are the new model that will bring about significant change to both the federal and state healthcare systems.

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3 Thomas E. Bartrum, et al., The ACO Handbook: A Guide to Accountable Care Organizations 3 (Peter A. Pavarini, et al. eds., 2012).

4 New York Public Health Law, art. 29-E.

5 Id.

6 New York Social Services Law, § 365-L.

MEDICAL INDEMNITY FUND DEVELOPMENTS *Continued from page 5*

receipt of services under the Fund does not give rise to a lien.

In addition, the care provided through the Fund is personalized in the sense that each child is assigned a case manager, which is a further indication that children enrolled in the Fund will receive the services that they require. Justice McKeon also feels that judges should be working closely with the Fund managers and suggested that it might be appropriate to incorporate a child's life care plan into a compromise order.

Remaining Questions

Other open questions not addressed to date are the interplay between the Fund and the availability of private insurance coverage, since the statute contains a collateral source provision which requires plaintiffs to use private insurance before resorting to the Fund.[11] Similarly, there may be issues regarding the apportionment of liability and the manner in which a settlement will be allocated in cases involving multiple defendants, although in this regard Justice McKeon has taken the position that the primary consideration is the allocation of damages, not the apportionment of liability among the tortfeasors. We will follow closely for further developments regarding these and other issues concerning the Medical Indemnity Fund.

[11] PHL § 2999-j(3).

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