

# In the New York State Courts

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## The New York Court of Appeals Rules that Filing a Claim Under New York's Whistleblower Law Does Not Bar a Simultaneous or Subsequent Claim Under New York's Health Care Whistleblower Law, and to Bring a Claim Under the Latter, an Employee Must Be Qualified to, and Actually Is Required to, Make Quality-of-Patient-Care Determinations

*Reddington v. Staten Island Univ. Hosp. et. al.*, 11 N.Y.3d 80 (2008). After receiving a right-to-sue letter from the Equal Employment Opportunity Commission, Plaintiff Carmel Reddington ("Reddington"), a former employee of Staten Island University Hospital ("Hospital"), brought suit against the Hospital and other defendants in the U.S. District Court for the Eastern District of New York. The suit alleged violations of various federal and state laws, including violations of New York's Whistleblower Law § 740 ("Section 740") and New York's Health Care Whistleblower Law § 741 ("Section 741").

In responding to a motion to dismiss, Reddington amended the complaint by withdrawing the Section 740 claim, which was time-barred, and several of the other claims. Defendants again moved to dismiss the complaint, which the District Court granted in part and denied in part. The District Court found that Reddington adequately pleaded several claims under federal and state laws, but dismissed her remaining claims, including that under Section 741. In dismissing the Section 741 claim, the District Court determined that Reddington waived this claim when she first asserted the Section 740 claim in her original complaint, pursuant to the election of remedies in Section 740. The District Court further noted that the Section 741 claim could have been dismissed, alternatively, because Reddington did not assert in the complaint that she actually performed



health care services while employed by the Hospital; rather, she worked for the Hospital as an interpreter and a volunteer coordinator.

In reviewing the District Court's decision on appeal, the Second Circuit Court of Appeals found no controlling rulings in New York State, and, in fact, found substantial disagreement between the state and federal courts related to the relationship between Section 740 and Section 741, and the scope of coverage provided by Section 741. Accordingly, the Second Circuit certified two questions to the New York Court of Appeals: (1) Does the institution of a time-barred claim pursuant to Section 740 simultaneously with a claim pursuant to Section 741 trigger the waiver provision in Section 740 and thereby bar the Section 741 claim even if the Section 740 claim is subsequently withdrawn? and (2) Does the definition of employee in Section 741 encompass an individual who does not render medical treatment, and under what circumstances? The New York Court of Appeals answered both questions in the negative.<sup>1</sup>

In answering the first certified question in the negative, the New York Court of Appeals noted that Section 740 and Section 741 have "uniquely interconnected elements," and that every Section 741 claim "expressly relies on and incorporates § 740 for purposes of enforcement." Specifically, Section 741(4) states that a health care employee may seek enforcement of Section 741 pursuant to Section 740(4)(d). Section 740(4)(d) states that a health care employee "who has been the subject of a retaliatory action by a health care employer . . . may institute a civil ac-

tion in a court of competent jurisdiction . . ." As such, Section 740—not Section 741—creates the private right of action for a health care employee. The New York Court of Appeals held that because Section 741 provides no independent private right of action, the pleading of a Section 741 claim after a Section 740 claim is instituted does not implicate any election of remedies under Section 740.

The New York Court of Appeals also determined that the election of remedies in Section 740 was included to prevent duplicative recovery—meaning a health care employee may recover damages either for a specific violation under Section 741 (through the enforcement mechanisms of Section 740), or for general violations under Section 740. A health care employee, however, cannot recover twice under both Section 740 and Section 741. Accordingly, the election of remedies found in Section 740 does not preclude a simultaneous or subsequent claim under Section 741.

In answering the second certified question in the negative, the New York Court of Appeals noted that the protections offered under Section 741 prohibit an employer from taking retaliatory action against an employee—defined as one "who performs health care services for and under the control and direction of any public or private employer which provides health care services for wages or other remuneration"—for disclosing, objecting to, reporting, or otherwise taking action with regard to anything the employee believes constitutes improper quality of patient care. The Court noted that this definition contains limitations both on the type of employer and the type of employee: (1) the employer must be in the business of providing health care services, and (2) the employee must perform health care services. After reviewing the plain meaning of "perform,"

the court construed this definition to mean that, to be qualified as a health care employee under Section 741, the employee must “actually supply health care services, not merely . . . coordinate with those who do.”

In further support of this interpretation, the court turned to the legislative history behind the enactment of Section 741. In so reviewing, the court found that the specialized protections offered under Section 741 were “meant to protect professional judgments regarding the quality of patient care,” not just to those employees who possess professional licenses but to any employee who, through training and/or experience, is qualified to make “knowledgeable judgments as to the quality of patient care, and whose jobs require them to make these judgments.” Accordingly, Section 741 does not encompass an employee who does not render medical treatment.

### **Southern District Dismisses Antitrust Suit Against Cardiothoracic Surgeons and Westchester County Medical Center Based on Immunity from Antitrust Liability Under the State Action Doctrine**

*Rocco J. Lafaro, M.D., et al. v. New York Cardiothoracic Group, PLLC, et al.*, No. 07-7984, slip. op. (S.D.N.Y. September 11, 2008); *appeal docketed*, No. 08-4621 (2d Cir., September 24, 2008). Cardiothoracic surgeons and their professional corporation (“Plaintiffs”) brought an action against other cardiothoracic surgeons and their professional group, New York Cardiothoracic Group, PLLC (NYCG), Westchester County Health Care Corporation (WCHCC) and Westchester Medical Center (WMC), with which the defendant physicians contracted, on an exclusive basis, for the provision of cardiothoracic services at WMC (the “Exclusive Agreement”). Plaintiffs practiced as cardiothoracic surgeons at WMC for a number of years prior to the Exclusive Agreement, and were permitted to continue practicing there pursu-

ant to a “grandfather” clause in the Exclusive Agreement.

Plaintiffs alleged that the Exclusive Agreement violated the federal Sherman Antitrust Act because it gave the defendant physicians latitude to determine use of the cardiothoracic operating rooms, and because new hires had to be approved by NYCG. Thus, Plaintiffs argued that the Exclusive Agreement, *inter alia*, limited patient choice and chilled competition for cardiothoracic patients at WMC. Plaintiffs also argued that the Exclusive Agreement prohibited them from expanding their practice within the hospital.

Defendants moved to dismiss Plaintiffs’ federal antitrust claims on various grounds, including that the Defendants were immune from antitrust liability under the State Action or *Parker Doctrine*, named for the seminal case *Parker v. Brown*, 317 U.S. 341, 63 S.Ct. 307 (1943). The District Court (Hon. Stephen C. Robinson) dismissed Plaintiffs’ Sherman Act claim based on the State Action Doctrine, and declined to maintain supplemental jurisdiction over the remaining state law claims.

In reaching its decision, the Court first analyzed the traditional two-prong test to establish State Action immunity, i.e., was it foreseeable to the state that WCHCC would act in an anticompetitive manner based on the authority granted to it, and did the state actively supervise WCHCC’s actions? As for the first prong, the Court initially cited to *Parker v. Brown*, *supra*, and explained that states acting as sovereigns are exempt from liability under the Sherman Antitrust Act, and that a state subdivision, such as a public-benefit corporation like WCHCC, enjoys the protection of State Action immunity when it acts “pursuant to a clearly expressed state policy” to displace competition. *See Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 39-40, 105 S.Ct. 1713 (1985); *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 98 S.Ct. 1123 (1978). To meet this element, the

Court noted that the state subdivision’s enabling legislation must make clear that it was “foreseeable” to the state that the entity could operate in a manner to suppress competition. *See City of Columbia v. Omni Outdoor Adver, Inc.*, 499 U.S. 365, 372-73, 111 S.Ct. 1344 (1991); *Cine 42nd St. Theatre Corp. v. Nederlander Org., Inc.*, 790 F.2d 1032, 1042-43 (1986).

Applying the law to this case, Judge Robinson pointed to WCHCC’s enabling statute which grants it, a public benefit corporation, the power, *inter alia*, “to enter into contracts . . . necessary or convenient or desirable for the purposes of the corporation to carry out any powers expressly given to it” and “[t]o provide health and medical services for the public directly or by agreement or lease with any person, firm or private or public corporation or association . . . and to make internal policies governing . . . health and medical services . . .” *See* N.Y. Pub. Auth. §§ 3305(11), 3306(2). The Court also focused on the provision of WCHCC’s enabling statute that grants the corporation the authority “[t]o determine the conditions under which a physician may be extended the privilege of practicing within a health facility.” *See id.* at § 3306(6). Based on these provisions, the Court concluded that the legislature intended for WCHCC to be free to enter into contracts with private parties to provide medical care, and that the state contemplated that WCHCC could and would impose restrictions with regard to doctors’ ability to practice at WMC in an anticompetitive manner. Thus, the Court held that under the first prong of the analysis, WMC and WCHCC were immune from antitrust liability under the State Action Doctrine, and were free to enter into the Exclusive Agreement with the individual physician defendants and NYCG.

Turning to the second prong, the Court relied on precedent, holding that publicly created state agencies, such as WCHCC, do not need to meet the “active supervision” prong

to be afforded State Action immunity because, as a public entity, their interests are necessarily aligned with the public's. See *Cine 42nd St. Theatre*, supra at 1047.

The Court also found the individual defendant physicians and NYCG to be immune under the State Action Doctrine based on Second Circuit precedent holding that private parties who contract with immune state agencies are likewise protected since "allowing successful tangential attacks on the [public entity's] activities through suits against third parties [acting in concert with it] would effectively block the efforts of the [public entity]" to perform its duties by contracting with third parties. See *Cine 42nd St. Theatre*, supra at 1048; see also *Electrical Inspectors, Inc. v. Village of East Hills*, 320 F.3d 110, 125-27 (2d Cir. 2003).

Finally, the Court rejected Plaintiffs' argument that WCHCC's enabling statute cannot be viewed as a clearly expressed state policy to displace competition due to the enactment of the New York Health Care Reform Act (HCRA), a hospital rate reimbursement statute. Plaintiffs argued that HCRA lead to a large-scale policy shift to deregulate hospitals, and that, as a result, for the State Action Doctrine to apply, WCHCC's enabling statute would have to affirmatively exempt it from the state's competition-favoring policies. The Court countered this by noting that Plaintiffs' position is undermined by the fact that the legislature, rather than relying on market forces, created the Commission on Health Care Facilities in the 21st Century (a/k/a the Berger Commission) to assess and decide which New York hospitals should be closed or restructured due to excess capacity. [Ed. Note: Garfunkel, Wild & Travis, P.C. represented the defendants in this suit.]

### **Southern District Dismisses False Claims Act Allegations That HIP Fraudulently Altered Data in Order to Obtain Accreditation Needed to Maintain a Contract with the U.S. Government**

*U.S. ex rel. Sterling v. Health Ins. Plan of Greater New York, Inc.*, slip. op., 2008 WL 4449448 (S.D.N.Y. September 30, 2008). In this suit brought under the Federal False Claims Act, 31 U.S.C. § 3729, the relator alleged that Health Insurance Plan of Greater New York, Inc. (HIP) fraudulently altered data in order to obtain accreditation needed to maintain a contract with the U.S. Government. Specifically, the relator alleged that after she performed a computer analysis to determine the percentage of children diagnosed with pharyngitis who were tested for strep throat showed that between 2.35% to 2.95% were tested, the relator's supervisor altered the data to reflect that 56.76% to 78.04% of the children were tested. The relator alleged that as a result of the fraudulent alteration, National Committee for Quality Assurance (NCQA) (HIP's accrediting agency) allegedly provided HIP with a high rating, and that had the government been aware that HIP generated such fraudulent data it would not have issued contracts and paid premiums to HIP.

The District Court granted HIP's motion to dismiss. First, the Court found that the relator failed to state a claim under the conspiracy provision of 31 U.S.C. § 3729(a)(3) because the complaint did not provide that two or more people from HIP were involved in the alleged fraud. Second, citing to the recent Supreme Court decision, *Allison Engine Co. v. United States ex rel. Sanders*, \_\_ U.S. \_\_, 128 S.Ct. 2123, 170 L.Ed.2d 1030 (2008), the Court dismissed the relator's claim pursuant to 31 U.S.C. § 3729(a)(2) because the relator failed to allege that HIP's alleged fraudulent statement to NCQA was made with the intent that the Government rely on it as a condition of payment. Third, the Court dis-

missed the relator's claim pursuant to 31 U.S.C. § 3729(a)(1) because the Court did not find that presentment of a false claim to NCQA, an independent accreditation organization, constitutes presentment of a claim to the government.

### **Insurer's Failure to Advise an Insured of the Right to Independent Counsel Under *Goldfarb* Held a Deceptive Business Practice Under New York GBL 349(a)**

In a 1981 decision, the New York Court of Appeals recognized that a conflict of interest arises between an insurer and its insured, in a litigation involving both covered and uncovered claims—i.e., where the insurer faces liability with respect to only some of the claims therein asserted, but the insured alone faces liability with respect to others. See *Public Service Mutual Ins. Co. v. Goldfarb*, 53 N.Y.2d 392, 401 (1981). Moreover, the *Goldfarb* court recognized that, in such cases, the insured is entitled to a defense attorney of its own choosing at the expense of the insurer.

In the case of *Elacqua v. Physicians' Reciprocal Insurers*, the New York Appellate Division, Third Department, rendered two decisions relative to *Goldfarb*. First, in *Elacqua v. Physicians' Reciprocal Insurers*, 21 A.D.3d 702, 707 (3rd Dep't 2005), the Court held that, upon becoming aware of a *Goldfarb* conflict of interest, an insurer has an affirmative obligation to advise its insured of the right to independent counsel at the insurer's expense.

Thereafter, *Physicians' Reciprocal Insurers* (PRI) entered into a settlement of the underlying action, which settlement satisfied all claims against the insureds. The insureds, licensed physicians Mary Elacqua and William Hennessey, and their LLP, continued their action despite the settlement, seeking to recover attorneys fees incurred in compelling PRI to indemnify them. Following a bifurcated trial on liability, the Supreme Court dismissed the complaint, and the in-

insureds appealed the dismissal of their General Business Law § 349(a) claim alleging deceptive business practices. The Supreme Court had found that the failure to inform an insured of its right to independent defense counsel at the insurer's expense, as recognized in *Goldfarb*, is a consumer-oriented deceptive business practice that is likely to deceive reasonable consumers—however, it dismissed the insureds' GBL § 349(a) claims on the ground that they had failed to demonstrate actual harm as a result of not being represented by independent counsel.

The Appellate Division reversed, holding that the failure to notify the insureds of their right to independent counsel, together with the insureds' showing that conflict-free representation had not been provided to them, constituted actual harm for purposes of GBL § 349(a). The Court cited the fact that the insureds had not been fully informed of the ramifications of a motion to dismiss the complaint only as against the physicians, which defeated liability on the part of PRI but left the LLP vicariously liable for uncovered claims alleging negligence by an employee nurse. Additionally, the attorney representing the LLP had fully joined in the motion, despite the fact that there were legally sufficient grounds upon which to base an opposition. The Court held that this demonstrated lack of independent representation, uncompromised by conflicts of interest, constituted sufficient harm to sustain a claim for deceptive business practices under GBL § 349(a). The case was remitted for a trial on damages.

### **Appellate Division Rules That a Physician Who Performs a Statutory Medical Examination Does Not Have a Physician-Patient Relationship with the Person Examined**

*Bazaokos v. Lewis*, 2008 WL 4356120 (2d Dep't September 23, 2008). Plaintiff sued Defendant, an orthopedic surgeon, for injuries allegedly sustained during Defen-

dant's statutory medical examination (IME) of Plaintiff. Plaintiff's IME was conducted in connection with a personal injury suit he had commenced. Plaintiff alleged that during his IME, Defendant "took [Plaintiff's] head in his hands and forcefully rotated it while simultaneously pulling," causing Plaintiff personal injury.

Approximately two years and 11 months after the IME took place, Plaintiff sued the examining physician for negligence. Defendant then moved to dismiss the complaint as time-barred, contending that the action was one for medical malpractice, which is subject to a two-and-a-half-year statute of limitations, rather than one of negligence, which is subject to a three-year statute of limitations. The motion court agreed with Defendant and dismissed the complaint. The Appellate Division reversed, in a 3-to-2 decision.

The majority reasoned that critical to a finding of a physician-patient relationship is the consensual nature of the relationship and the expectation and receipt of medical services by patient for a medical condition. Here, the Court noted that there was no patient at all in this relationship, only an examinee compelled to participate in an adversarial situation because of the rules pertaining to pre-trial discovery and disclosure in personal injury actions. The Court also noted that the examining physician was not engaged in diagnosis and treatment on the examinee's behalf but for the benefit of a defendant, defense counsel, and a defendant's insurance carrier. Lastly, the Court looked to the legislative history of CPLR 214-a, which makes clear that the period of limitations for medical malpractice actions was shorted from three years to two-and-a-half years as part of a comprehensive overhaul to deal with the critical threat to the delivery of health care services, and not to provide "a significant litigation advantage to physicians not engaged in providing health care services, but instead engaged in business relation-

ships structured to provide expert witness services to insurance carriers in the defense of personal injury litigation."

The dissent cites prior Appellate Division rulings that support the proposition that the examinee and the physician conducting a statutory medical examination are indeed in a patient-physician relationship, albeit a limited one that merely imposes a duty upon the physician to conduct the examination in a manner that does not affirmatively injure the examinee. Accordingly, the dissent found that the two-and-a-half-year statute of limitations for medical malpractice should apply and, therefore, concluded that the complaint was properly dismissed by the lower court as time-barred.

### **Court Holds That Defendants Cannot Apportion Liability to Non-Party Physician Father of Medical Malpractice Plaintiff Based Solely on Ordinary Parental Care Given to Offspring**

*Antaki v. Lerman*, No. 00662806, Decided 09/22/08, 10/8/2008 N.Y.L.J. 28 (col. 1). Defendants in a medical malpractice suit filed a motion, pursuant to CPLR 1601, to charge liability to non-party Dr. Antaki.

Plaintiff is a 36-year-old man with cerebral palsy, who was suffering from severe diarrhea. Dr. Antaki, a retired or semi-retired pathologist, is Plaintiff's father. As a consequence of Plaintiff's condition and after Dr. Antaki spoke with the family physician, Plaintiff was taken to the hospital for treatment. Dr. Antaki was with Plaintiff in the Emergency Room, but Plaintiff signed the consent forms. After approximately four hours, Plaintiff felt better, and he was given a prescription and sent home. His father, Dr. Antaki, signed the discharge sheet, although Plaintiff had signed the initial consent forms himself.

A few days later, Plaintiff felt progressively worse, and Dr. Antaki called the family physician, who sug-

gested that Dr. Antaki listen for bowel sounds. Dr. Antaki did so and reported to the physician that Plaintiff did have bowel sounds. Plaintiff was later admitted to a different hospital, and later underwent surgery.

The Supreme Court ruled that, except in rare and egregious circumstances, the ministrations of a parent, who happens to be a physician, in the ordinary care of his or her offspring, shall not be deemed to create a physician/patient relationship capable of resulting in medical malpractice liability.

In reaching its decision, the Court first analyzed the applicability of CPLR 1601, which may reduce or affect the respective liability of the named defendants if there is a plaintiff's verdict against one or more of same. When the liability of a single named defendant exceeds 50%, that defendant shall be responsible for all commensurate "non-economic loss" established by the plaintiff. When the named defendant's liability is less than 50%, however, such named defendant shall be responsible only for its proportionate share.

The Court noted that application of this rule to Dr. Antaki would, in effect, constitute an indirect claim for malpractice by a son against his parent.

The Court determined that Article 16, though it is a diminution provision, cannot be invoked to attribute liability to a parent in the absence of any clear and convincing showing of authority. The court pointed out that Plaintiff was 36 years old at the time, and had the mental capacity to make his own decisions. To hold a parent responsible under these circumstances would flip the familial and nuclear family and institution to such a degree that it would, in effect, prohibit a parent from giving any sort of advice.

The Court concluded that in the interest of justice and in the interest of maintaining societal equilibrium,

fairness, the family unit and its hierarchy and responsibilities, there cannot be a determination, except under the most grievous of circumstances, that could hold the parent responsible for any kind of advice or action given to the child. Accordingly, the court ruled that Dr. Antaki's interaction with his son was that of a parent with his offspring, rather than a physician with his patient.

### **Court Holds That Doctor's Statements in IME Report Are Protected by Absolute Privilege**

*Kaisman v. Carter*, 13 Misc.3d 1227(A), 831 N.Y.S.2d 348 (Table) (Sup. Ct., N.Y. County 2006). Plaintiff physician brought a defamation action for statements made about him by Defendant, also a physician. The statements in question were made in an independent medical examination report (IME report) prepared by Defendant in connection with a personal injury action brought by a plaintiff identified as Ms. L.C.

In Defendant's IME report detailing his findings regarding Ms. L.C., he included an "editorial comment" that Plaintiff, an anesthesiologist, performed an unnecessary lumbar dissection on Ms. L.C., a procedure usually performed by a surgeon. Defendant also stated, "There is a certain lack of morality and good clinical judgment in an anesthesiologist performing such a procedure . . . it is inappropriate and, in my view, immoral for the anesthesiologist to perform surgical procedures whose complications he cannot himself treat. I must say that given the total lack of findings on physical examination or MRI, there was no good reason to submit this woman to an unneeded procedure. . . ."

Defendants moved, pursuant to CPLR 3211(a)(7), for summary judgment dismissing the complaint on the basis that the statements are afforded the privilege of absolute immunity, and are otherwise protected as opinion. Plaintiff opposed the motion on the basis that the statements are, at

most, subject to a qualified privilege, because they were only tangentially related to a legal proceeding.

The Court found that the statements made by Defendant in the IME report were protected by an absolute privilege, noting that "[s]tatements made by parties, attorneys, and witnesses in the course of a judicial or quasi-judicial proceeding are absolutely privileged, notwithstanding the motive with which they are made, so long as they are material and pertinent to the issue to be resolved in the proceeding" (*Sinrod v. Stone*, 20 A.D.3d 560, 561-562, 799 N.Y.S.2d 273, 274 (2d Dep't 2005)). The Court explained that statements made in connection with a judicial proceeding are broadly construed to be "pertinent" for the purpose of absolute immunity in order to protect counsel, witnesses and parties to a judicial action, and encompass not only statements that are pertinent, but also those statements which may become pertinent.

To support its conclusion, the Court relied on the reasoning in *Aequitron Medical, Inc. v. Dyro*, 999 F.Supp. 294 (E.D.N.Y. 1998). In that case, the Court held that experts' statements in a video tape, made after the commencement of an action, were absolutely privileged, and it was of no import that the statements were made during trial preparation rather than in open court, because the experts were retained to provide their opinion concerning whether a product was defective.

Similarly, Defendant was retained as an expert to evaluate Ms. L.C.'s injuries, treatment and progress, and his statements were material and pertinent to the issues to be resolved in the underlying personal injury action, and thus afforded immunity from litigation. The Court rejected Plaintiff's contention that, at most, Defendant's statements were entitled to qualified privilege and, accordingly, dismissed Plaintiff's defamation action.

## **Appellate Court Affirms Ruling That Nurse's Examination of Injured Child Falls Within the Good Samaritan Law Shielding Nurse from Liability**

*McDaniel v. Keck*, 53 A.D.3d 869, 861 N.Y.S.2d 516 (3d Dep't 2008). Plaintiff brought personal injury action against an elementary school, which took its students on a bus trip to a private school/working farm, and against a nurse who was at the farm to provide nursing services to the school's students. Plaintiff appealed from the Supreme Court's decision dismissing her complaint seeking to recover damages for an eye injury that her child, who was not a student at school, sustained while on farm premises. The school moved to dismiss the complaint against it on the ground that the nurse was an independent contractor, not an employee of the school, and thus the school could not be vicariously liable. The nurse cross-moved to dismiss the complaint as to her on the ground that her conduct was protected by the Good Samaritan law.

The Appellate Division dismissed Plaintiff's complaint in its entirety, ruling that the nurse was entitled to immunity under Good Samaritan statute in connection with her examination of child, and since the claim against the school relied upon purported vicarious liability for the acts of the nurse, the Court consequently dismissed the claims against the school.

In reaching its decision, the Court first analyzed whether the nursing Good Samaritan statute applied. That statute provides, in relevant part, that a nurse is liable only for acts or omissions constituting gross negligence when the nurse "voluntarily and without the expectation of monetary compensation renders first aid or emergency treatment at the scene of an accident or other emergency, outside a hospital, doctor's office or any other place having proper and necessary medical equipment, to a person who is unconscious, ill or injured." Education Law § 6909[1]. The statute

further states that "[n]othing in this subdivision shall be deemed or construed to relieve a licensed registered professional nurse or licensed practical nurse from liability for damages for injuries or death caused by an act or omission on the part of such nurse while rendering professional services in the normal and ordinary course of her [or his] practice." Education Law § 6909[1].

The Court pointed out that the overriding purpose of the Good Samaritan statute is to encourage laypersons and professionals to help those in need, even when they are under no legal obligation to do so, by providing immunity from liability claims arising out of an attempt to assist a person in peril.

In applying the statutory law to this case, the Court reasoned that the nurse was under no duty to render assistance to the child. She was at the premises to provide nursing services exclusively to the elementary school students, of which the child was not one. The nurse volunteered to help with the child and she had no expectation of monetary compensation for such assistance. While her examination of the child occurred in the farmhouse and not the barn where the accident occurred, the farmhouse is where the child presented himself in distress immediately after the injury and, under the circumstances, the Court found this to be sufficiently close in time and proximity to being at the scene of an accident or emergency within the meaning of the Good Samaritan statute.

The Court noted that the Good Samaritan statute's exclusion for care within a hospital, doctor's office, or other place having proper and necessary medical equipment did not apply to this case because the nurse was located in a room in a farmhouse with no medical equipment or supplies other than a first-aid kit supplied by the elementary school for its students on a bus trip to a farm and a similar first-aid kit that the farm had available.

Based on the foregoing, the Court ruled that the nurse's examination of the child fell within the general purpose of the Good Samaritan law and each of the specific statutory criteria applicable to a nurse providing treatment in this state was established. There was no contention of gross negligence and, accordingly, the complaint against the nurse was dismissed.

## **Southern District Upholds DOH's Regulation Prohibiting Medicaid Reimbursement for Treatments of Gender Identity Disorder**

*Casillas v. Daines*, \_\_\_ F. Supp. 2d \_\_\_, 2008 WL 3157825 (S.D.N.Y. 2008.) Plaintiff filed suit against the New York State Department of Health (DOH) for the denial of Medicaid coverage for surgeries and services that Plaintiff claimed were medically necessary to treat her Gender Identity Disorder (GID). The DOH denied Medicaid coverage for an orchiectomy (removal of testes) and vaginoplasty (removal of penis and creation of a vagina) pursuant to a DOH regulation that "prohibits state Medicaid reimbursements for treatments for the 'purpose of gender reassignment (also known as transsexual surgery).' 18 N.Y.C.R.R. § 505.2(1)." In response, Plaintiff filed a lawsuit claiming that the denial of Medicaid coverage deprived her of rights secured by the federal Medicaid statute and the Fourteenth Amendment. The DOH moved for judgment on the pleadings, which was granted by the Court.

In her lawsuit, Plaintiff asserted three causes of action pursuant to 42 U.S.C.A. § 1983, claiming that three sections of the federal Medicaid statute unambiguously confers a right to Medicaid coverage for the GID treatments and surgeries that her doctor claimed were medically necessary. Specifically, Plaintiff asserted that a right was created by: (1) the Medicaid statute requiring that the state make assistance available to certain broad categories (42 U.S.C. § 1396(a)(10)(A)), (2) the Medicaid statute "prohibit-

ing discrimination against or among categorically needy persons” (42 U.S.C. § 1396a(a)(10)(B)(i)) and (3) the Medicaid statute requiring the state to develop “reasonable standards” for its plan” (42 U.S.C. § 1396a(a)(17)). Plaintiff also asserted one cause of action claiming that the denial of Medicaid coverage violated the Equal Protection Clause of the Fourteenth Amendment.

The Court began its analysis of Plaintiff’s Section 1983 claims by noting that “not all violations of a federal statute by a state official are actionable” and that Plaintiff carried the burden of showing that “a right secured by a federal statute has been violated.” To carry this burden a plaintiff must establish (1) that the statute unambiguously confers a right to support a cause of action brought under Section 1983, (2) that the right is not so vague that its enforcement would strain judicial competence, and (3) that the statute unambiguously imposes a binding obligation on the state.

The Court held that each of Plaintiff’s three Section 1983 claims failed the first two prongs of this test and the Court, therefore, did not consider the third prong. In rejecting these claims, the Court stated that “nothing in the statute suggests that participating states are required to fund every medical procedure that falls within the delineated categories of medical care” and that the statute allows for “categorical limits on treatments.”

Specifically, the Court focused on the Secretary’s regulation, 42 C.F.R. § 440.230(d), which affords a state the authority to “place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.” The Court noted that “in the Secretary’s view, Section 1396a(a), permits a state plan to place ‘appropriate limits’ upon a ‘service’ regardless of an individual medical doctor’s view of the appropriateness of the categorical limitation.” The Court held that the three sections of the federal Medicaid statute relied on by the Plaintiff were all subject to this regulation. As such, the allowance of appropriate limitations precluded a finding that those three sections of the statute unambiguously confer the right to Medicaid treatment for the GID services sought by Plaintiff, and that enforcing the statutes in the manner suggested by Plaintiff would strain judicial competence. Accordingly, the Court dismissed all of Plaintiff’s Section 1983 causes of action.

The Court also dismissed Plaintiff’s claim that New York’s regulation prohibiting Medicaid reimbursements for gender reassignment surgeries violated the Equal Protection Clause of the Fourteenth Amendment. Plaintiff did not assert that she was a member of any suspect class or that the denial of Medicaid reimbursement for the GID surgeries implicated a fundamental right. Accordingly, this claim was governed by the rational basis standard.

In dismissing this claim, the Court recognized that “in adopting the prohibition, the DOH cited ‘serious complications’ from the surgeries and danger from life-long administration of estrogen.” The Court dismissed Plaintiff’s final cause of action, finding that this “provided a more than sufficient rational basis which was related to legitimate government interests—the health of its citizens and the conservation of limited medical resources.”

## Endnote

1. Justice Smith issued a partial dissent, answering the first certified question in the affirmative.

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