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MLMIC Announces 20% Dividend

MLMIC's Board of Directors is pleased to announce the approval of a 20 percent dividend for all MLMIC policyholders who are insured as of May 1, 2016, and maintain continuous coverage through July 1, 2016.

MLMIC's mission is to provide insurance at the lowest possible cost. To offset premiums, we offer dividends to our policyholders whenever possible. These dividends are generally declared when MLMIC has sufficient resources to meet its policyholder obligations and when its operating results are better than expected.

Our competitors often promise low initial premiums to attract business, but MLMIC continually operates without a profit motive. Instead, we work to provide much needed relief to our policyholders, while maintaining financial stability.

MLMIC remains a mutual insurer, owned by our policyholders, and we are committed to policyholder-first service. Over the years, MLMIC's financial strength has allowed us to pay more than $300 million in dividends to our policyholders, an accomplishment unmatched by other insurers.

MLMIC Policyholders looking for further information on this dividend should contact the Underwriting Department at the MLMIC office nearest their location. ❖

Use of Summary Judgment in a Medical Malpractice Case

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One of the most distressing moments a physician, nurse, or other healthcare provider can experience is learning that he or she has been named as a defendant in a medical malpractice lawsuit. Among the first questions posed to defense counsel is how the individual can be dropped from the litigation. How this can be accomplished varies, depending on the stage of the case.

For instance, if another defendant, such as a hospital, appears to be the "target," the plaintiff's counsel will sometimes agree to discontinue against a nurse, resident, or attending physician shortly after the initiation of the case. However, this is not always possible due to potential prejudice the plaintiff may suffer if the client is later found to be more involved than initially appreciated.

Another method that is sometimes successful in medical malpractice actions is a summary judgment motion. This is a formal request to the court to obtain a judgment in a party's favor without the need for trial, or to clarify what issues will be raised at trial. Summary judgment can be used to seek dismissal of the entire case or particular claims, for example a claim for lack of informed consent. A successful summary judgment motion must demonstrate that there are "no genuine issues of material fact," essentially meaning a judge or jury could

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The Americans with Disabilities Act

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Many issues arise when professionals provide services to individuals who are protected by both Federal and New York State laws which prohibit discrimination based on disability. The definition of a disabled individual covered by these laws is very broad and was expanded by amendments to the Federal Americans with Disabilities Act (ADA) that became effective January 1, 2009. It is important to be aware that the law protects not only those individuals with obvious impairment, but any individuals with a physical or mental/cognitive condition even if the condition is not overt. Certain diseases are also protected by this law.

The ADA defines a disability as a physical or mental impairment that substantially limits one or more of a person's major life activities including, but not limited to "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working."[1]

A disability also includes having a record of an impairment and/or being regarded as having an impairment.[2] New York State defines a disability as a "physical, mental or medical impairment resulting from anatomical, physiological, genetic or neurological conditions which prevents exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques, or a record of such an impairment, or a condition regarded by others as such an impairment."[3]

Risk Management Issues

Since private medical offices are considered to be places of public accommodation,[4] they must abide by State and Federal laws. We recommend that every physician perform a careful office assessment to evaluate and determine whether the office environment protects and facilitates the treatment of patients with disabilities. As part of the assessment, all of the following questions should be considered:

- Do barriers exist which might create a risk to the safety of a patient with a disability and could this risk result in the physician's liability or allegations of discrimination?
- Will a disabled (or even an elderly) patient be safe if left alone, even momentarily, on an examination table? Should this patient be left alone?
- If a patient who is visually or hearing impaired is left alone in an examination room, how will the patient communicate with the physician or his/her staff to obtain any necessary assistance?
- How are appointments made? Does the office have access to, or are the physician and his/her staff knowledgeable about, assistive interpretive devices and the use of interpreters and services? How does the physician communicate with a hearing-impaired patient in the event of an emergency? Is an interpreter or other assistive device or service promptly available, if needed?
- Are elevators and bathrooms handicapped accessible?
- Are sufficient office parking spots available for handicapped individuals?
- Are doors sufficiently wide for a patient to enter the office in a wheelchair? Are appropriate methods available to safely transfer such patients from the wheelchair to the examination table for examination and/or treatment, without injuring the patient, physician and/or staff?
- Is a staff member available to assist a patient with a physical disability who needs to use the bathroom to stand up safely from a chair or examination table?
- If a patient has a cognitive or mental impairment, does the office ensure that the patient is accompanied by an aide or relative who is legally authorized to provide consent for treatment as well as an accurate health and medical history, such as known allergies, a current list of medications the patient is taking, and other relevant information?
- Are visually impaired patients given verbal instructions for treatment and care? Are consent forms read to them? When providing a prescription for medication or discharge instructions after a procedure, is a careful verbal explanation given to the patient? Does the physician request that the patient repeat the consent discussion or instruction back to him/her in order to confirm that the patient understands?
- Are wheelchairs, examination tables and other equipment and furniture sufficiently large and strong enough to accommodate patients who are morbidly obese?

1. 42 U.S.C.S. § 12102 (2)(a).
2. 42 U.S.C.S. § 12102 (1).
3. Executive Law § 292 (21).
4. 42 U.S.C.S. § 12181 (7)(F).

Risk Management Recommendations

Physicians must address the environment of care inside their offices from a risk management perspective in order to avoid allegations of discrimination when patients with protected disabilities seek care at their practices. The most obvious areas of concern are the waiting room, the examination tables, the bathroom facilities, handicapped access in the parking area, and access when entering the office. Important risk management recommendations include the following areas:

Accessibility

The patient must be able to get on and off an examination table with assistance. While on the examination table, the patient must be protected from falling, and/or reasonably and safely assisted with hygiene needs, if necessary. Access into the office, the waiting room, and bathrooms must be sufficiently large and safe for the use of wheelchairs and other assistive devices and also must be free of obstacles. Liability for falls or other injuries sustained by patients due to the physical environment of the office is a concern which co-exists with discrimination.

Documentation

Another problem identified by many physicians is what to document about the patient and how to do so. This is of particular concern when the patient is HIV-positive. New York State HIV law[5] permits the documentation of all relevant HIV-related information and the patient's HIV status in the record. However, once this information is documented, whether the HIV-related information is positive or negative, it becomes highly sensitive information accorded special protections. Further, State law requires a Notice of Prohibition Against Redisclosure to be sent with a copy of the medical records when they are released.[6] Finally, any authorization

to release records containing HIV-related information to a third party must include specific consent to release such information.[7] Similar legal protection is afforded to those patients whose records include psychiatric treatment or treatment in federally funded substance abuse programs.[8]

Infection Control Guidelines

Physicians and their staff must follow Occupational Safety and Health Administration (OSHA) regulations[9] for exposure to blood and body fluids, since the HIV and hepatitis status of every patient may not be known. This requirement for protection of employees is governed by OSHA regulations. Additionally, a patient's medical record containing HIV-related information must not be specially flagged, nor otherwise made obvious to staff and others, merely to "protect" them from exposure to infection. Physicians have a legal duty to enforce compliance with the OSHA regulations.

Confidentiality

The statutory protections of patient confidentiality and against discrimination for HIV, mental health treatment, and alcohol and drug treatment are stringent. Discussions of a patient's HIV status, inpatient or outpatient treatment for mental illness, or alcohol/drug abuse must only take place in a completely private area. Only individuals who have a need to know this information for their specific duties should be informed. Finally, access to protected patient records must be limited to only those staff members who need to know or review the contents of the records to carry out their duties.[10]

Fager Amsler & Keller, LLP recommends that all medical practices have a written confidentiality policy in place so the staff clearly understands both the responsibilities and consequences they will face if they improperly disclose, at any time, a patient's Protected Health Information (PHI), and particularly

5. Public Health Law § 2700 et. seq.
6. Public Health Law § 2782 (5)(a).
7. Public Health Law § 2782(1)(b). Except for documentation of the routine offering of a test to patients ages 13-64 pursuant to PHL § 2781-a which does not require special consent, only the Notice of Prohibition Against Redisclosure.
8. 42 C.F.R. §§ 2.31, 2.33; Mental Hygiene Law §§ 33.13, 33.16.
9. 29 C.F.R. § 1910.1030.
10. Public Health Law § 2782 (1)(c), (d); 42 C.F.R. § 2.13 (a), Mental Hygiene Law § 33.13 (f).

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Case Study

Failure to Provide a Sign Language Interpreter

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A 78-year-old deaf patient was admitted to a hospital for revascularization of her leg, an arteriogram, and a femoral popliteal bypass. She had a history of hypertension, COPD, and several allergies. She had a long history of leg pain. One day postoperatively, she experienced chest pains. Her EKG revealed changes of a non-Q wave inferior infarction accompanied by a slight CPK rise. She was moved to a cardiac monitoring unit.

In addition to the patient, her daughter was also deaf. Upon admission, both had requested a sign language interpreter. At this time, the hospital provided a person from the audiology department to interpret. The patient and daughter objected to the use of this individual because she was not a certified interpreter. However, this person did have a history of education in sign language interpretation and was qualified to sign for deaf patients.

During the patient's stay, the hospital used the services of this interpreter only intermittently. On the unit, the nurses used gestures and written notes to communicate with both the patient and her daughter, who was her caretaker. No interpreter was provided from the day after admission through the fifth postoperative day. Four days prior to her discharge, an interpreter was occasionally provided. Finally, on the day of her discharge, the patient was seen by a certified interpreter from a nearby school for the deaf. She interpreted all of the discharge instructions and other necessary information. The patient was then transferred to an extended care facility where this certified interpreter provided services.

The patient's son-in-law was an attorney. He brought an action in federal court on behalf of both the patient and her daughter under the Americans with Disabilities Act. He alleged that the facility had failed to provide effective communication for the patient and daughter and that they were denied appropriate and fair access to the facility's necessary services because of their disability. He also alleged that the facility had violated on multiple occasions 10 NYCRR § 405.7 of the New York State Hospital Code (Patient Bill of Rights), which imposed a duty upon the hospital to provide an interpreter skilled in sign language.

He also alleged that both women suffered emotional distress causing physical and emotional injuries due to the negligent, wanton, and reckless actions of the hospital. He claimed this resulted in an unforgettable, degrading, and traumatic experience for this patient. He also specifically alleged that a qualified sign language interpreter should have been provided to the patient's daughter, since she too was not able to communicate with the physicians and nurses about her mother's condition, any changes in that condition, and her mother's diagnosis, symptoms, and needs for future treatment. This was crucial since she assisted her mother at home. Finally, he alleged there was a breach of informed consent to the various treatments and procedures the patient underwent, since no effective communication had taken place between the professional staff and the patient.

The patient demanded $2 million in compensatory damages as well as punitive damages. The case was settled on behalf of the facility for $60,000 but only for malpractice-related allegations. The final disposition of this case with respect to violations of the Americans with Disabilities Act and New York State regulations is not known.

A Legal & Risk Management Perspective

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Both the patient and her daughter were deaf. The patient lived with and was cared for by her daughter. Because of that, both mother and daughter were entitled to reasonable accommodations under the Americans with Disabilities Act (ADA),[1] the New York State Human Rights Laws,[2] and the New York Health Code Rules and Regulations.[3] They requested that a "certified" interpreter be provided. However, the law does not require a "certified" interpreter. Instead, a "qualified" interpreter who can provide "effective" communication must be provided. Therefore, initially,

1. 28 C.F.R. § 35.130, 28 C.F.R. § 36.303.
2. Civil Rights Law § 40-c.
3. 10 NYCRR § 405.7(a)(7)(ix)(a).

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LEGAL Update

Davis v. South Nassau Communities Hospital: Liability for Failure to Warn of Medication Side Affects

On December 16, 2015, the New York State Court of Appeals held an emergency room physician and hospital liable to the general public for failing to adequately warn a patient of the risks and side effects of the medications administered to her.[1] The patient arrived at the Emergency Department at 11:00 p.m. in pain. An intravenous dose of Dilaudid, an opioid narcotic, and a benzodiazepine drug were administered to her. The patient was then discharged at 12:30 a.m.

The patient was not warned that the side effects of the medication would impair her ability to operate an automobile. Nor did they ask the patient if she drove herself to the hospital. The patient was discharged approximately 90 minutes after receiving the medications and subsequently drove her car across a double yellow line, striking a bus. The plaintiff who operated the bus sued both the facility and the physician's group. He alleged that these defendants owed a duty to the plaintiff and his wife to warn the patient that these medications impaired her and that her ability to drive an automobile safely could also be impaired. The Court agreed and held that a physician is required to advise patients of the side effects of medications. This holding significantly expands the legal duty and thus the liability of a medical provider to the general public. Previous cases only imposed such liability to third parties in very unusual situations involving close family or special relationships. The Court based its expansion of the duty of care on the fact that the third party's injury resulted from the breach of duty of care owed to the patient.

Unfortunately, the outcome of this case would have been very different if the physician had provided informed consent regarding the risks of these IV drugs and then clearly documented this discussion in the patient's medical record. Although the Court stated that there is no requirement to prevent a patient from leaving an office or facility after the administration of medication, prudence would dictate that the patient should have been sent home by taxi or with another driver. ❖

1. Davis v. South Nassau Communities Hospital, 2015 NY Lexis 3897, 2015 WL 8789470 (2015).

Dealing with Patients Who Have Compromised Driving Ability

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An article on this topic originally appeared in the Fall 2005 issue of Dateline. *The following article reflects changes in the law that have taken place since that publication.*

One of the most difficult decisions an individual faces is whether and when to surrender his/her driver's license and stop driving. The loss of independence that results may be so difficult to accept that an individual may refuse to do so voluntarily. Although a person may have a safe driving history, the development of some physical and mental conditions may preclude his/her safe operation of a motor vehicle. The decision to discontinue driving is a dilemma that is not unique to older drivers. Younger patients may have or develop seizure disorders, visual difficulties, hearing problems, or other mental or physical conditions that affect the neuromuscular system and alter depth perception and reflexes. As a result, physicians are often in a quandary regarding the extent to which they are obliged to report to the New York State Department of Motor Vehicles (DMV) when they believe a patient should not be operating a motor vehicle.

The DMV may suspend or revoke a driver's license if there are reasonable grounds to believe that a licensed driver is not qualified to drive a motor vehicle.[1] However, it is the responsibility of the person holding the license to report the loss of use of one or both hands or arms, one or both feet or legs, or one eye.[2] If the patient loses the use of both eyes, his/her New York State driver's license shall

1. Vehicle and Traffic Law § 506 (1).
2. Vehicle and Traffic Law § 506 (4).

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Dealing with Patients Who Have Compromised Driving Ability *continued from page 5*

be null and void.[3] Finally, State law provides that whenever a driver is required to give the Commissioner of Motor Vehicles notice of a disability, "no person shall operate any motor vehicle until such notice has been given."[4]

When the DMV receives notice of a potentially unsafe driver, it can require the driver to undergo an evaluation, a vision, written, or road retest, or a medical examination. Age alone, however, must not be the determining factor when the DMV takes action against a licensee.[5] The Commissioner may not revoke or suspend a driver's license in an arbitrary or capricious manner.[6] There must be a reasonable basis for doing so.

Physicians are often aware that patients rarely comply with the requirement to report a disabling condition. The DMV receives information about the skills and abilities of drivers from a variety of sources. These include responses to medical questions posed on the renewal application, accident reports (including statements provided to the police as part of a police report or investigation), and letters from family members or other third parties. While many physicians believe they have a duty to notify the State when they identify a potentially unsafe driver, the law does not support their position. In fact, the physician has no legal obligation to report to the DMV that a patient has a medical condition that might reasonably impair his/her ability to drive, e.g. uncontrolled seizures, blindness or other severe visual impairment, dementia or an injury to one or more limbs that affects his/her driving ability, judgment, or reflexes. Further, the physician cannot report any protected health information (PHI) to the DMV without first obtaining the patient's consent. The DMV, on its website,[7] advises that a physician is not required to report a medical condition, but, in the interest of the health and safety of all highway users, the physician should do so promptly. This statement conflicts with both HIPAA and New York State patient confidentiality laws, which require patient consent, and thus adds to the confusion.

In order to avoid violating state and federal confidentiality laws, physicians must understand the distinction between mandatory reporting and permissive reporting made without patient consent. HIPAA regulations permit health care providers to divulge a patient's protected health information (PHI) without a patient's authorization only if such disclosure is required by law. However, disclosure of PHI without the patient's written authorization (unless required by law) may lead to allegations of professional misconduct.[8] State law also protects the confidentiality of any personal information a patient provides to an individual who is licensed to practice medicine, a registered nurse, a licensed practical nurse, a dentist or a chiropractor.[9] There is no legal requirement under New York law for a physician to report any medical condition to the DMV, even in the event of blindness or uncontrolled seizures. Therefore, physicians should obtain the patient's written authorization prior to releasing any information to the DMV, including completing medical evaluation reports for license renewal forms.

If the patient has not notified the DMV of a new medical condition, the physician should make a very serious attempt not only to obtain the patient's consent to notify the DMV, but also to dissuade the patient from driving. For reasons more fully explained below, this discussion must be documented to

3. Vehicle and Traffic Law § 506 (5).
4. Vehicle and Traffic Law § 509 (9).
5. Feely v. Hults, 27 A.D. 2d 953 (2d Dep't, 1967).
6. Application of Sidney, 24 Misc. 2d 335(1960), aff'd. 13 A.D. 2d 613 (4th Dep't, 1961).
7. http://dmv.ny.gov/driver-license/frequently-asked-questions-medical-conditions, accessed on 12/28/2015.
8. Education Law § 6530 (23).

protect the physician from liability to third parties. If the patient authorizes the physician to discuss his/her concerns with family members, such as by filling out a HIPAA form, or if a family member is present during the discussion with the patient, the physician should inform the family member of the patient's duty to report the condition to the DMV. Further, the physician must warn both the patient and any family present of the consequences to the patient and others if the patient continues to refuse to stop driving. All efforts to convince the patient or family members must be fully documented in the patient's medical record. If the patient permits the physician to send a medical evaluation form to the DMV, the DMV may notify the driver that his/her license has been indefinitely suspended. The suspension will then continue until the physician has certified in writing that the patient's condition no longer interferes with his/her ability to drive. Physicians must be cautious not to succumb to the pressure of patients and families to certify that the patient is able to drive when the physician does not believe this to be true.

The DMV may also require a driver to undergo both vision and road tests if there are reasonable grounds to believe that such retesting is necessary. For example, in one case, an individual who struck a flag person in a construction area had his license revoked. His physician was asked to submit a medical report to the DMV, and consent was obtained from the patient. The report confirmed that the patient had performed poorly on an eye test and that his condition would likely interfere with his ability to drive. As a result of this evaluation, the DMV ordered the patient to take a road test, which he then failed. This resulted in the revocation of his license. Upon appeal, the court found there was a reasonable basis for the action taken by the DMV.[10]

Physician's Duty When Driver has Experienced Loss of Consciousness or Seizures

All applicants, upon an original application for or renewal of a driver's license, must submit proof of fitness.[11] The Commissioner of Motor Vehicles may suspend or revoke a driver's license at any time because of a driver's physical or mental disability. If the DMV is advised, either by a police report or by the applicant's own admission on his/her application, that the applicant has lost consciousness, a physician's written statement is required stating that the patient has:

- not lost consciousness during the last 12 months.
- experienced a loss of consciousness that was solely related to a change in medication.
- experienced a loss of consciousness within the last 12 months, but the physician believes that the condition will not interfere with safe operation of a vehicle.[12]

The patient will not be granted a new license, or have a license restored, without the physician's statement. Once again, it should be emphasized that unless the patient consents, the physician has no independent duty to report this information to DMV, and it could result in a violation of confidentiality laws to make such a report.

Patients with Visual Acuity Problems which Affect Driving

When a patient requests that the physician administer a vision test for renewal of a driver's license, and the patient is unable to meet the visual standards set forth by the DMV, the physician must refuse to confirm that the patient has appropriate visual acuity as required by the DMV for such renewals. Applicants undergoing a visual acuity test must meet one of three standards. The DMV also requires that the examination be performed by certain licensed professionals including a physician, PA, ophthalmologist, optician, registered nurse or nurse professional.[13] The professional who administers the visual examination must specify whether the patient has any limitations and whether the patient's visual acuity has deteriorated.

When a patient's vision has deteriorated to the point where he/she is legally blind, i.e. a central visual acuity of 20/200 or less in the better eye with the use of a corrective lens, or a visual field of 20 degrees or less, the physician must report this to the New York State Commission for the Blind and Visually Handicapped.[14] This is the only mandatory reporting obligation on the part of physicians. Note that the report is not made to the DMV, nor does this obligation permit a report to the DMV. The written report to the Commission must include the patient's name, address, and age, as well as any additional information required by the Commission.[15] The Commission for the Blind and Visually

9. CPLR § 4504 (a).

10. Yanulavich v. Appeals Bd. of Admin. Adjudication, Bureau of the N.Y. State Dep't of Motor Vehicles, et. al., 2 A.D. 3d 955 (3d Dep't, 2003).
11. Vehicle and Traffic Law § 502 (1), 15 N.Y.C.R.R. § 9.1.
12. 15 N.Y.C.R.R. § 9.3.
13. http://dmv.ny.gov/driver-license/vision-requirements-restrictions Accessed 1/14/16.
14. Unconsolidated Laws § 8704 (b).
15. Unconsolidated Laws § 8704 (a).

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Dealing with Patients Who Have Compromised Driving Ability *continued from page 7*

Handicapped has seven district offices located throughout New York State. When a vision test reveals that an individual is certified as legally blind, the DMV may deny his/her original or renewal application for a driver's license and suspend the individual's license or learner's permit.

Liability to the General Public

It is not uncommon for a physician to know that the patient should not be driving a motor vehicle, but the patient refuses to stop. The family may resist asking the patient to stop, or refuse to make a report to the DMV because of the convenience of having the patient continue to drive. Driving has very deep emotional significance. When patients consider this loss of independence, particularly in rural and suburban areas where there is no readily available public transportation, they often refuse to stop driving, despite the known risks.

Physicians have long been concerned about their liability to the general public for accidents which seriously injure the patient or an innocent third party. This concern is realistic, given the 2015 Court of Appeals decision in Davis v. South Nassau Communities Hospital. In Davis, a patient was treated for pain in the Emergency Department of a hospital. She received intravenous Dilaudid, an opioid narcotic painkiller, and Ativan, a medication used to treat anxiety. Despite the fact that the package insert for Dilaudid includes a warning that the drug might impair a patient's mental or physical ability to perform hazardous tasks such as driving, the providers failed to warn the patient of these adverse effects. The patient was discharged from the hospital 1½ hours after the medications were administered. Shortly after the patient was discharged, she was involved in a motor vehicle accident with a bus. The bus driver sued the hospital and emergency medicine physician group. The Court of Appeals held that the providers had a duty to the plaintiffs to warn the patient that the drugs she received would impair her ability to operate an automobile.[16] The Court emphasized that the physician's duty was to warn the patient, but there was no obligation to restrain the patient or prevent the patient from leaving the hospital.[17]

Although it is not yet clear whether the holding in this decision will be expanded, the lesson to be learned from the Davis case is that it is prudent for the physician to fully inform and warn a patient of the risk of medical conditions which can impair the patient's ability to drive a car or heavy machinery, and to fully document those warnings in the patient's medical record. If the patient is properly warned, and this warning is well documented, it is less likely that a physician will be held liable for the patient's actions.

Risk Management Tips

As noted above, it is critical to document in the patient's medical record that you advised the patient of his/her condition and how it impacts driving ability, including the risks of continuing to drive and the basis for those risks. If relevant, and you have consent to do so, also advise the patient's family that the patient should not be driving, due to the impact of the patient's medical condition and/or medications which impacts the ability to drive safely. Documentation must include the following information:

- How the patient's medical condition(s) and/or medications preclude the safe operation of a motor vehicle.
- All attempts made to warn the patient and, with appropriate consent, the family that the patient should discontinue driving or not drive because of the side effects of the medication or condition.
- All forms completed on behalf of the patient and sent to the DMV (after receiving the patient's written authorization).
- Copies of the patient's written authorization to release information.
- All attempts to obtain consent from the patient or his/her legal representative to release information about the driver's medical condition to the DMV.
- Copies of reports sent to the Commission for the Blind and Visually Handicapped, if applicable.
- Copies of records of any telephone calls with the patient and/or family regarding the patient's medical condition and medication and his/her inability to safely drive.

In conclusion, while physicians may have serious concerns about their duties to patients who are impaired or disabled in a manner which would impede safe driving, due care must be taken to avoid breaching the patient's confidentiality. Only when a report is mandatory or when a patient has given consent in writing to permit the physician to notify the DMV should such a report be made. However, all efforts must be made to warn the patient and, if applicable, the family. These warnings must be clearly documented to avoid liability to the general public.

If you have any questions, please contact counsel at Fager Amsler & Keller, LLP to discuss the particular facts of each situation. ❖

16. Davis v. S. Nassau Communities Hosp., 2015 N.Y. Lexis 3897 at *3 -4.
17. Id at * 23 - 24.

The Americans with Disabilities Act *continued from page 3*

HIV-related, mental health or alcohol and drug treatment information. Staff must be oriented to, and annually re-educated about, infection control and confidentiality laws and guidelines. Documentation of such education must be placed in their personnel files.

Patient Restraints

The use of patient restraints is generally not acceptable when treating patients from a facility or organization governed by the Office for People with Developmental Disabilities (OPWDD). However, what is even more important, and sometimes more difficult, is restraining oneself during an examination or treatment from responding to a patient bite or agitation in an inappropriate and "abusive" manner. Such a response is often reflexive. For example, if a patient hits or bites a physician or staff member, and the individual reflexively slaps the patient, the ramifications can be severe. This may even include adverse licensure action for patient abuse, regardless of whether the action was unintentional.

Interpreters

Another very thorny issue for many practitioners is the obligation to obtain a sign language interpreter for hearing impaired patients at their request, even though there is no reimbursement for this expense. Physicians often question whether it is acceptable to use pencil and paper or other communication devices, rather than obtaining an interpreter.

A public accommodation must furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities.[11] The type of auxiliary aid or service necessary to ensure effective communication varies, depending on the method of communication used by the patient, the nature, length, time and complexity of the communication involved, and the context in which the communication is taking place. Medical offices should consult with individuals with disabilities whenever possible to determine what type of auxiliary aid is needed to ensure effective communication, but the ultimate decision as to what measures to take rests with the provider, so long as the method chosen results in effective communication.[12]

When a patient or a companion[13] of the patient asks a physician for a specific accommodation, such as a sign language interpreter to provide effective communication, we recommend that the physician accede to the request. Handwritten notes are often incomplete, time consuming, and cursory. The patient might miss crucial information, which can lead to errors, patient injury, and potential malpractice claims. More importantly, since a physician must frequently communicate critical information to a patient, such as an informed consent discussion about a treatment, procedure or a new medication, it may not be reasonable or appropriate to communicate this information without the aid of a qualified interpreter. A provider may not rely on an adult accompanying an individual with a disability to interpret or facilitate communication, unless:

- there is an emergency that presents an imminent threat to the patient or the public and no interpreter is available.
- an individual with a disability specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances.[14]

The physician cannot require the patient and/or companion to bring another individual to interpret for him/her.[15] Moreover, a provider may not rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available.[16]

If acceptable to the patient, physicians may choose to provide equipment, such as telecommunication devices for the deaf (TDD), instead of an interpreter. These devices must also be able to provide effective communication between the physician and patient so they can communicate about making appointments, scheduled procedures, or any other type of information that one party must communicate to the other. However, if this equipment fails or is otherwise not acceptable to the patient after its use and the patient requests an interpreter, one should be provided. Physicians must "give primary consideration to the requests of an individual with disability."[17] Regardless, we recommend a qualified interpreter be used whenever important doctor-patient discussions, such as obtaining informed consent or a medical history, are necessary.

Informed consent discussions are crucial when obtaining consent for invasive or potentially high risk treatment. The patient must be able to receive that information from a qualified interpreter

11. 28 C.F.R. § 36.303 (c)(1).
12. 28 C.F.R. § 36.303 (c)(1).
13. Companion "means a family member, friend or associate of an individual seeking access to, or participating in, the goods, services, facilities, privileges, advantages, or accommodations of a public accommodation, who, along with such individual, is an appropriate person with whom the public accommodation should communicate." 28 C.F.R. § 36.303 (c)(1)(i).
14. 28 C.F.R. § 36.303(c)(3)(i)
15. 28 C.F.R. § 36.303(c)(2).
16. 28 C.F.R. § 36.303(c)(4).
17. 28 C.F.R. § 35.160 (b)(2).

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in order to fully understand it and provide a valid consent. The discussion must include the risks, benefits, and alternatives of the proposed plan, including the risks of no treatment, and the risks of any available alternatives. The patient's inability to hear may also necessitate the use of pictures in addition to interpreters. If possible, patients should be given simple brochures to read about a particular treatment or procedure as an adjunct to the interpretation provided. The office staff should be educated about the needs of patients with disabilities and, particularly, the special needs of deaf patients and the reasonable accommodations which must be provided to them.

Sometimes a patient with a hearing disability demands the use of the interpreter service of their choice rather than using an auxiliary assistive device such as Video Remote Interpreting (VRI). Be aware that there are times a VRI is not suited to the task because of technical or other limitations. Further, many interpreting services claim that it is a legal (ADA) requirement for a physician to provide a certified interpreter. This claim is not correct. The ADA requires only that the interpreter be a qualified interpreter, which means that the individual is "able to perform the tasks of interpretation appropriately and accurately in a given situation."[18]

The cost of retaining an interpreter is often more than the cost of the actual visit, although this fee can be taken as a business expense for tax purposes. However, it is still "negative math." The charges often include not only the time the interpreter is present, but also travel expenses and full fees for missed patient appointments. Some services demand their fees "up front." When a physician has a noncompliant patient who fails to keep multiple appointments, this cost can be discouraging. However, the cost of personally defending a discrimination proceeding is far greater than absorbing the cost of an interpreter. If you fail to provide an interpreter, the patient may commence malpractice litigation alleging a breach of informed consent and/or file a claim of discrimination with a government agency such as the Equal Employment Opportunity Commission (EEOC) or New York State Division for Human Rights (DHR). Malpractice insurers do not cover complaints filed with government agencies because it is against public policy. An insurer is precluded from defending statutory violations, as well as the payment of fines or penalties assessed by a government agency. However, you should still notify MLMIC of any claim or lawsuit made against you by an individual because it is possible that some of the allegations made will fall within your policy coverage.

Service Animals

Practitioners may believe that service animals are only used by persons who are visually impaired. This is not the case. When an individual who is visually impaired or otherwise physically disabled brings a service animal to an appointment, he/she may insist that the animal be permitted to accompany them into non-public areas of the office, such as treatment or operating rooms. How to respond to these requests may create problems for the staff.

Sometimes, patients allege that office staff must be responsible for care for the animal during the patient's examination or procedure. However, when a patient brings a service animal to an extended appointment for treatment, or to a facility where he/she will undergo a procedure, the law does not require that staff be responsible for caring for the animal.[19] It is the patient's responsibility to arrange for care of the animal, not that of a physician, staff, or facility.

Service animals can be excluded from the premises when they are either disruptive, or a "direct threat." A direct threat is a "significant risk to the health or safety of others that cannot be eliminated by reasonable accommodations."[20] A dog that is out of control, is not housebroken, or whose handler fails to take appropriate action to prevent hygiene problems and/or is not restrained on a leash or tether, can be considered a direct threat. The specifics of the "direct threat" must be documented by the physician in order to justify the exclusion of the animal and an alternative accommodation provided to the patient.

Finally, interior examination and treatment rooms are not considered to be "public areas" due to concerns about infection control. Service animals can be excluded from those areas. However, the patient must still be given a reasonable accommodation when taken to non-public areas. This accommodation may include physically assisting the patient to and from the public areas in a safe manner, such as in a wheelchair.

Due to recent changes in the law, the definition of a service animal has been limited to dogs.[21] These changes did not affect the right of a disabled patient to use a service horse to assist in movement. However, dogs used for other purposes, such as protection from violence, rescue, or emotional support, are not considered service animals and do not require any reasonable accommodations.

There are certain limitations pertaining to the use of service animals. A service dog must be trained to perform specific tasks and, as noted, not merely provide emotional support. Tasks these animals can perform include:

18. Beth Schoenberg and Beth Carlson, "Interpreters: Certified or Qualified?" (1999). Accessed at http://www.signonasl.com/doc/interpreters_certified_or_qualified.pdf.
19. 42 C.F.R. § 35.136 (e). U.S. Dep't of Justice, Civil Rights Division, ADA Standards, Service Animals (2011). Accessed at http://www.ada.gov/service_animals_2010.htm on November 5, 2015.
20. 42 U.S.C.S. § 12111 (3), 28 C.F.R. § 35.136.
21. 28 C.F.R. § 35.104.

- assisting blind individuals or others with poor vision with navigation;
- alerting deaf patients to other people, dangers, and sounds;
- pulling a wheelchair;
- assisting during a seizure;
- alerting the patient to possible allergens;
- retrieving items for the person, or accessing the telephone;
- physically supporting the individual and assisting with balance and stability; and
- helping psychologically or neurologically disabled patients prevent or interrupt impulsive or destructive behaviors.

Physicians and/or staff often are uncertain what questions they can ask a patient who brings in a service animal about the patient's need for that animal. The law does not permit the patient to be questioned about the nature of his/her disability. Nor can the patient be asked whether the dog is certified, licensed, or trained as a service animal. There are only two questions which the physician can ask the patient: 1) is the animal required because of a disability? and 2) what tasks has the animal been trained to perform?

Below are several real life scenarios which have involved problems with patients who had service animals:

- A patient who had a service animal to warn him of impending seizures requested admission to a locked mental health unit in a medical facility. The patient also demanded that the dog be admitted with him and the staff of the facility care for the dog while he was on the unit. The patients on this locked unit had unpredictable behaviors. Thus, there was a "direct threat" to both the dog and the other patients by agreeing to his demands. Additionally, the staff was not required to provide care for this service animal during this patient's admission, so the patient was informed that other arrangements would have to be made for the animal during this admission.[22]
- A patient came to the waiting room of a clinic for an appointment. He had a service horse pulling his wheelchair. The horse became nervous, broke loose from the tether, and ran around the public area of the facility, leaving excrement all over the waiting room floor. The service horse was excluded from the facility and other reasonable accommodations were provided to the patient because the horse created a direct threat to other patients, was out of control, and soiled the premises.[23]
- A 1999 case decided by the Appellate Division, 4th Department, and affirmed by the New York State Court of Appeals, is also relevant to the issue of service dogs in the medical office setting.[24] The patient was in an examination room with her service dog. When the doctor came in to the room, he allegedly yelled at the patient because the dog's head and mouth were on the examination table. The patient claimed discrimination and sued the physician.

The key issue in this case was whether an examination room was considered a public area. If it was, the physician could not bar the dog from that room. However, the court decided that an examination room is NOT a public area. This decision specifically confirmed that private offices and medical facilities may have public and private areas which co-exist under the same roof.

22. 42 U.S.C. Section 12182 (b) (3).
23. 28 C.F.R. § 36.302 (c)(9).
24. Albert v Solimon, 684 N.Y.S. 2d 375, aff'd by 94 N.Y. 2d 771 (1999).

Discharging or Refusing to Treat Patients

The most significant risk a physician faces is discharging, refusing to treat, or refusing to even accept a disabled patient because of the cost of a reasonable accommodation, e.g., an interpreter. A physician must not use the cost of the accommodation as the reason not to accept a patient, and the patient must not be charged for that cost.

In a case decided by the Eastern District Court in Michigan, the plaintiff requested an interpreter for her December 1992 visit, and the physician provided and paid for one. In January 1993, the physician wrote a letter to accompany the payment for the interpreter and sent a copy to the patient. The physician stated she could no longer use the interpreter service. The defendant charged $40 for a 15 minute visit. Medicare paid $37.17 and the patient would pay $9.29. The physician further indicated that her overhead was 70% of her gross receipts, so her profit for this visit was $13.94. When the $28 charge from the interpreter was paid, the physician contended she had lost money on the visit. The physician further stated, "I certainly hope that the Federal Government does not further slash this outrageous profit margin." The patient interpreted the physician's letter as stating that the physician would not hire an interpreter and that she had been discharged as a patient. The physician claimed the letter was meant to protect her from the ramifications of the ADA.

The Court held that the patient had clearly proven that she was disabled, that the physician's office was a place of public accommodation, and that the physician discriminated against the patient based on her disability. The physician's January 1993 letter was evidence of her intent to refuse to provide an interpreter

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The Americans with Disabilities Act *continued from page 11*

and discharge the patient from care. The patient's request for interpreters for future office visits was documented in her medical record. At another office visit, the physician documented advice to the plaintiff to see an ophthalmologist and bring along someone to sign for her.[25]

Many of the early discrimination cases brought under the ADA and New York State Human Rights laws involved the alleged refusal of physicians to treat patients because of their HIV positive status, which is considered a disability. However, a physician can discharge or transfer a patient with a disability if there is a non-discriminatory and legitimate reason to do so. Therefore, it is crucial to have substantial written documentation of the reason(s) for the discharge. As long as the reason for discharge is not the cost of the accommodation, or the disability itself, and all patients are treated similarly (i.e., referral to a specialist for treatment the physician does not provide), physicians can discharge disruptive, threatening, or hostile patients, as well as consistently noncompliant or nonpaying patients who happen to have a disability. Again, it must be emphasized that this pattern of behavior must be well-documented in the medical record. The behavior should not merely occur only one time, unless the patient has exhibited actual violent acts or made serious, documented, and realistic threats of violence in the office against the physician or his staff.

In conclusion, physicians must understand that treating patients who are protected under the ADA and New York State Human Rights laws can be difficult and may be costly. However, all patients, with or without a disability, are entitled to reasonable and appropriate quality care. Patients should not be refused or discharged solely because they have a disability. Physicians must be knowledgeable of what state and federal laws consider a disability. Finally, a physician's risk of being sued for discrimination can be greatly diminished by fully complying with applicable state and federal anti-discrimination and confidentiality laws. ❖

25. Mayberry v. Von Valtier 843 F. Supp. 1160 (E.D. Michigan, 1994).

Use of Summary Judgment *continued from page 1*

not find for the opposing party based on the facts. A key component of such a motion in a medical malpractice action is an affirmation or affidavit from an expert physician attesting to the care rendered and explaining why it was consistent with the standard of practice and/or did not cause the injury claimed by the patient. Motions for summary judgment are made after the close of the "discovery" phase of the lawsuit, during which each party obtains evidence through production of medical records, depositions, and other formal demands for information.

A summary judgment motion is the paper equivalent of a trial. Much like developing the defense of a case to be tried before a jury, a summary judgment motion requires extensive preparation. To avoid having the motion denied by the judge based upon a technicality, the attorney must work to secure supporting evidence in admissible form. The supporting evidence may include the opinion of a physician, certified copies of the patient's medical records, and the sworn deposition testimony of the parties. Further, recent developments in the law have imposed the arduous requirement that attorneys redact all confidential personal information from the motion papers and supporting exhibits.

If the evidence submitted in support of a summary judgment motion is not in admissible form, i.e. uncertified records, the court may deny the motion without considering the merit of the arguments. Further, the court may reject motion papers that are not properly redacted. In addition to these requirements, the courts impose very strict deadlines for the filing of summary judgment motions. Absent "good cause," a judge will deny an untimely summary judgment motion without considering its merit.

Therefore, to avoid the risk of preclusion and losing the opportunity to obtain summary judgment, it is crucial that counsel obtain supporting evidence in admissible form so that a timely summary judgment motion can be filed. It is important to analyze a case in its early stages to explore possible ways to dispose of it before trial. If there is a potential basis for making a summary judgment motion, or if it is necessary to oppose a summary judgment motion by the plaintiff, early expert retention is recommended so that the case can be thoroughly reviewed and an expert can support the motion. If the motion is successful, the burden and expense of a trial may be avoided. ❖

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UNDERWRITING Update

The Importance for Policyholders to Insure with a Financially Sound Insurance Company—Just How Important is an Insurer's Financials to its Insureds?

Robert Pedrazzi
Assistant Vice President, Underwriting
Medical Liability Mutual Insurance Company

True to the old adage of "if it seems too good to be true, it probably is," seemingly lower cost medical malpractice insurance coverage (also commonly referred to as medical professional liability insurance—"MPLI") available in the marketplace today is often accompanied by the troubling, but frequently overlooked, state of an insurer's financial condition.

While insuring with a company that offers deeply discounted rates may provide immediate relief to its insureds, potential financial repercussions from possible inadequate rating could quickly lead to an insurer's demise and leave its policyholders with a myriad of problems and unnecessary worry.

As it is commonly known that medical malpractice insurance is a volatile line of business, prospective insureds who may find themselves drawn in to companies offering such "lower rates" may overlook the fact that responsible carriers concern themselves more with the financial viability of their companies to ensure stability and longevity for their insureds, instead of just focusing on attracting new business. Losing sight of the former could easily "fast track" a carrier into insolvency, leaving its policyholders scrambling for coverage and solutions.

As many healthcare professionals and their administrators may have witnessed within the series of recent health insurer Consumer Operated and Oriented Plan (Co-Op) failures, liquidation of a carrier in any line of business can lead to the detriment of many. While this matter pertains to an entirely separate line of business, it illustrates the importance of financial condition and insolvency protection for all insurers, MPLI companies included. The health insurance co-ops that were formed under the Affordable Care Act were built on the model of deeply discounted health insurance premiums as their appeal, but, as history proved, many were unsustainable, resulting in their ultimate liquidation. While the intentions of this endeavor were noble, the foundation that these programs were built on did not account for any financially extenuating circumstances, like the steep reductions that occurred in federal "risk corridor program payments," which were designed to assist these co-ops.

MLMIC, as part of its mission to provide affordable MPLI at the lowest possible cost consistent with fiscal responsibility, continues to operate on the basis of maintaining a sound financial foundation to ensure the fulfillment of its obligations to its policyholders. By nature, MPLI requires risks to be underwritten with a full understanding of the exposures and with the knowledge to price the coverage responsibly. Companies that choose to ignore underwriting principles in favor of increased market share can find themselves in dire financial straits. Moreover, as history has proven, some have become unable to continue operating, sliding into insolvency and ultimate liquidation by their State's regulatory agency.

Throughout our history, MLMIC has always adhered to responsible protocol. However, that is not to say that the Company does not afford premium relief when feasible. To date, MLMIC has issued dividends to its insureds totaling over $300 million. Given our exceptional financial condition, MLMIC has announced issuance of another dividend in the amount of 20% to its insureds as of May 1, 2016 who maintain continuous coverage through July 1, 2016. Irrespective of this distribution, our financials will continue to provide a more than adequate level of surplus to

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New Electronic Forms and Applications at MLMIC.com

MLMIC has converted its online Physicians & Surgeons, Extender and Allied Healthcare Providers applications, as well as supplemental forms (Policy Administrator, Part-Time Physician, Legal Defense Costs Coverage and Bariatric Surgeons), to a new PDF type-able format that allows applicants to complete all forms electronically. They can then simply print, sign and submit them to us via one of the three indicated delivery methods. This enhancement allows applicants to handle many transactions at their convenience, with a prompt response time in some cases as early as 24 hours.

RISK MANAGEMENT Tips

Tip #19: Treating Patients with Whom You Have a Close Relationship

Physicians are often asked by close friends, relatives, or colleagues for medical advice, treatment, or prescriptions both inside and outside of the office. At times, these individuals may be seen at no charge as a courtesy. Although the American Medical Association advises physicians not to treat immediate family members except in cases of emergency or when no one else is available, this practice continues to exist.

Unfortunately, over the years, we have seen a number of lawsuits filed against physicians by close friends, colleagues, and even their own family members because of care provided by our insureds. The defense of these suits is frequently hampered by the fact that there are often sparse or entirely non-existent medical records for the patient. The failure to maintain a medical record for every patient is defined as professional medical misconduct in Education Law § 6530(32).

Providing care under these circumstances may pose unique risks. Here are some suggestions on how to handle these situations:

1. Always create a medical record for friends, relatives, and colleagues for whom you provide care of any kind.

2. All patient encounters must be documented in the medical record, including those that occur outside the medical office.

3. A thorough medication history should be obtained to avoid potential drug interactions and identify any contraindications.

4. Take a complete history when seeing friends, relatives, or colleagues as patients. If indicated, this should include issues that may be uncomfortable to discuss such as the use of psychotropic medications and sexual history.

5. Perform a thorough physical examination. Sensitive portions of a physical examination should not be deferred when pertinent to the patient's complaints. These may include a breast, pelvic, or rectal examination. A chaperone may be necessary for those portions of the exam.

6. Do not write prescriptions for individuals with whom you do not have an established professional relationship and always document the reasons for prescribing the medication and dose. If narcotics are prescribed, the Prescription Monitoring Program (I-STOP) must be checked.

7. If a surgical procedure is to be performed, a signed informed consent must be present in the record, with accompanying documentation that the requisite risks, benefits, and alternatives to the treatment have been discussed with the patient. ❖

UNDERWRITING Update *continued from page 13*

ensure our future claims paying ability. As indicated in the Company's website blog of December 2, 2015, *"MLMIC's third quarter (2015) financial statement indicates that the company's overall financial condition is sound, with assets of $5.9 billion, liabilities of $4.1 billion and a policyholders' surplus of $1.8 billion."* Our strong financial backing permits the Company to continue meeting its obligations to its policyholders, providing them with piece of mind so they can focus on what's most important to them.

As previously mentioned, MPLI is a volatile line of business and is cyclical in nature. Downward trends tend to make many new carriers reconsider or reduce their exposure to the market, in some extremes withdrawing from it altogether, resulting in their insureds being forced to have to quickly find replacement coverage. MLMIC, as a mutual insurer whose primary line of business is MPLI, is owned solely by its policyholders and is a proven company with longevity and dedication stretching through decades of cyclical outcomes. In our 40-plus years of operation, MLMIC has remained committed to the MPLI marketplace, even during times of extreme adversity. Our policyholders can be assured by their Company's solid track record of providing them with the security that they are entitled to. Having no outside "shareholders" to answer to, especially during uncertain times, ensures our unsurpassed staying power commensurate to our mission. ❖

THE MLMIC Library

Spring 2016 Update

The MLMIC Library's services are available to all policyholders on a complimentary basis and may be accessed via MLMIC.com by selecting the MLMIC Library link at the bottom of the home page under Risk Management. In-depth research services are also available to all policyholders.

The following resources are newly acquired and/or pertain to topics featured in this issue of *Dateline*. Visit the MLMIC Library to learn more about these titles and borrow up to five items from our extensive collection. Or, contact Judi Kroft, Library Services Administrator at 800-635-0666, ext. 2786 or via e-mail at jkroft@mlmic.com.

- **Building a high-reliability organization: Toolkit for success.** Gary L. Sculli and Douglas E. Paull. HCPro Division of BLR; 2015 (R M 151-145).
- **Decision making in behavioral emergencies: Acquiring skill in evaluating and managing high-risk patients.** Phillip M. Kleespies. American Psychological Association; 2014 (Psych 133-060).
- **Enterprise risk management handbook for healthcare entities.** Roberta L. Carroll. American Health Lawyers Association; 2013 (R M 151-131 2013).
- **Error reduction in health care: A systems approach to improving patient safety.** Patrice L. Spath. Jossey Bass Publishers; 2011 (R M 151-084 2011).
- **Essential guide for patient safety officers.** Joint Commission Resources; 2013 (R M 151-132 2013).
- **HIPAA Rules & Compliance.** DuPont Sustainable Solutions; 2013 (DVD 002-611 2013).
- **Hospital and healthcare security, 6th edition.** Tony W. York and Don MacAlister. Butterworth-Heinemann; 2015 (Safety 152-035 2015).
- **Negligent credentialing lawsuits: Strategies to protect your organization.** Amy E. Watkins. HCPro, Inc.; 2005 (Med Staff 113-081).
- **Safer hospital care: Strategies for continuous innovation.** Dev Raheja. CRC Press LLC; 2011 (R M 151-144).
- **Strengthening nurse-physician relationships: A guide to effective communications.** HCPro; 2005 (DVD 002-551).
- **Strengthening nurse-to-nurse relationships: A guide to ending horizontal hostility.** HCPro; 2007 (DVD 002-550).
- **Taming disruptive behavior.** William "Marty" Martin, Phillip Hemphill. American College of Physician Executives; 2013 (R M 151-141).

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The attorneys at Fager Amsler & Keller, LLP are available during normal business hours to assist MLMIC insureds with a wide range of legal services, including, but not limited to, advisory opinions concerning healthcare liability issues, liability litigation activities, lecture programs, and consulting services.

Healthcare law, regulations, and practices are continually evolving. The information presented in Dateline *is accurate when published. Before relying upon the content of a* Dateline *article, you should always verify that it reflects the most up-to-date information available.*

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Case Study

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the hospital met its legal responsibilities to these individuals.

Once the patient was admitted to the surgical unit, and for the next five days, there was no attempt to provide effective communication. This violated state and federal laws. Gestures and notes were not sufficient to effectively communicate with the patient and her daughter under the circumstances. Their continuous requests for an interpreter were ignored. Alternatively, the facility could have attempted to substitute appropriate interpretive devices and equipment, if this would have provided effective communication on a 24/7 basis, when a qualified interpreter was not available. If/when the patient found such devices to be ineffective, the hospital would have been required to provide a qualified interpreter within 20 minutes.[4]

Because of these failures, a lawsuit was commenced on behalf of both women alleging a breach of informed consent as well as violating the ADA and state Human Rights Law. The patient and her daughter both had legitimate basis to bring the lawsuit against the hospital. They also had the right to file complaints against the facility with the U.S. Department of Justice, Civil Rights Division; the New York State Division of Human Rights; and the New York State Department of Health.

The medical malpractice allegations contained in the patient's lawsuit centered primarily around informed consent. The patient alleged that the facility's failure to provide her with an interpreter deprived her of the ability to provide valid informed consent for all procedures performed during the five-day period when no qualified interpreter was provided. From a liability perspective, this was a legitimate concern. The MLMIC experts who reviewed this case determined that this allegation could not be defended. Thus, the malpractice aspect of the case was settled solely on that basis.

The rest of the allegations in the lawsuit were based upon multiple violations of federal and state statutes and regulations. Statutory violations of this type cannot be covered or defended by insurance companies as a matter of public policy, and, therefore, the facility was solely responsible for the costs of defending against these allegations, as well as payment of any damages awarded and all penalties and fines later imposed by government agencies. ❖

4. 10 NYCRR § 405.7(a)(7)(ix)(a).