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EXECUTIVE MESSAGE

Dear Colleagues,

Phew! We all dodged a bullet. For now.

As many of you are no doubt aware by now, on January 30, Governor Hochul vetoed a bill that would have greatly expanded liability in wrongful death cases brought against medical professionals and the facilities these professionals work within frequently. This legislation, S74A/A6770 of 2022, would have added a new category of subjective damages that could be recovered by the family of the person who died as an alleged result of medical negligence. These damages would allow for recovery of grief or anguish and any disorders caused by such grief or anguish. Given the lack of any objective measure of such damages, the potential awards in wrongful death cases would have definitely increased, possibly by significant amounts. In fact, the highly respected actuarial firm Milliman estimated that the costs of these new damages could have increased medical liability premiums by up to 40 percent.

MLMIC Insurance Company had been lobbying against the bill — in concert with our trade associations, the New York Insurance Association and the Lawsuit Reform Alliance, and our healthcare partners, such as the Medical Society of the State of New York and the Healthcare Association of New York State — even before it passed both houses of the New York Legislature. Once the bill passed, MLMIC swung into action in close coordination and collaboration with all of the aforementioned organizations, our affiliate MedPro, and numerous other property and casualty insurers to mount both a public advocacy campaign and a lobbying effort with the Governor's office designed to bring attention to the enormous new costs this legislation would impose on all New Yorkers due to greatly increased liability. Fortunately, these efforts bore fruit with the Governor's veto.

However, the veto does not mean an end to efforts by supporters of this fundamentally flawed legislation to achieve passage again in both houses and obtain enactment through the Governor's approval sometime this year. One thing I want to make very clear is that MLMIC does not reject the notion of any reform to New York's current wrongful death statute, but the vetoed bill did not represent a reasonable compromise measure that would modernize the statute while also containing costs. MLMIC has a policy that we will seek to pay on behalf of our policyholders' truly meritorious claims, but we will also always zealously advocate for our policyholders when claims are not truly meritorious. In addition, we will always oppose any legislation to expand medical liability in New York.

Given the wrongful death supporters' clearly expressed intent to move forward with a new effort during this legislative session to advance the bill through both houses and obtain the Governor's approval, MLMIC is already hard at work laying the groundwork for an advocacy effort designed to inform and educate both legislators and the Governor's office regarding the enormous costs an open-ended bill changing the current wrongful death law, such as this vetoed one, would impose on New York.

I want to sincerely thank all of the MLMIC policyholders and stakeholders who took the time to write a message to the Governor's office in opposition to the legislation.

As always, I welcome any feedback you may have regarding *The Scope*, including ideas for future articles.

Thanks,

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Healthcare and Firearms: What the New York Physician Needs to Know

Over the past 10 years, the State of New York has taken steps to reduce the incidence of gun violence. Many of these efforts have focused upon keeping firearms out of the hands of individuals who may be prone to violence, efforts that impose responsibilities upon healthcare providers. In light of recent judicial and legislative action related to New York's firearm laws, this article will address New York physicians' duties regarding their patients and access to firearms.

The New York SAFE Act

In 2013, Governor Andrew Cuomo signed the New York State Safe Act (NY SAFE Act) into law. This legislation was a direct result of the December 14, 2012, Sandy Hook Elementary School shooting and the December 24, 2012, Webster, New York shooting that caused the deaths of two firefighters. While there are many provisions to the Safe Act, this article will further speak to the bipartisan legislation that amended the New York State Mental Hygiene Law. This law required mental health professionals (including physicians, psychologists, registered nurses, and licensed clinical social workers) to report to authorities "if they conclude, using reasonable professional judgment, that [an] individual is likely to engage in conduct that would result in serious harm to self or others."

> **While there are many provisions to the Safe Act, this article will further speak to the bipartisan legislation that amended the New York State Mental Hygiene Law.**

Under the law, if county officials agree, the person's name is put into the state database for 5 years. If the person has a gun permit, they must relinquish their license and any guns they own and/or are in their possession. Other individuals will remain in the database and are barred from obtaining a permit to purchase a gun.[1]

New York Penal Law §265.01-e: The Concealed Carry Improvement Act. In July 2022, Governor Kathy Hochul signed legislation that was created to address the recent U.S. Supreme Court decision of *NYSRPA v. Bruen*, which found aspects of New York's "concealed carry" rules unconstitutional. The legislation amended New York State Penal Law by adding a comprehensive list of what the new law defines as "sensitive locations" where the possession of firearms, rifles, or shotguns are prohibited, and is a crime to possess such weapons in these locales. "Sensitive locations" under the law include places providing healthcare, behavioral health, or chemical dependency care. They also include locations with programs licensed, regulated, certified, funded, or approved by the Office of Children and Family Services, Office for

1. On March 11, 2013, the United States Department of Veterans Affairs announced that it would not follow the provision of the NY SAFE Act requiring mental health professionals to report patients who seem more likely to hurt themselves or others, as federal laws protecting the privacy of veterans take precedence over state laws. Advocates for military veterans had expressed concern that the reporting requirement would deter some people from seeking needed treatment.

People with Developmental Disabilities, Office of Addiction Services and Supports, and the Office of Mental Health. Other locations include residential settings licensed, certified, regulated, funded, or operated by the Department of Health, all educational institutions, and summer camps.

In September 2022, the Concealed Carry Improvement Act (CCIA) came into effect. While the law remains in effect, there is pending litigation, *Antonyuk v. Hochul*, which immediately challenged the law as unconstitutional. A New York-based federal judge issued a temporary restraining order (TRO) and preliminary injunction limiting enforcement of certain portions of the law, including its application to behavioral health locations considered "sensitive locations" under the law. The Second Circuit Court of Appeals stayed enforcement of the TRO and preliminary injunction, so the law remains in effect pending consideration by the court.

New York's "Red Flag" Law

In 2019, New York enacted legislation creating a duty to warn in order to address the purchase of firearms by persons who had psychiatric illnesses. The Red Flag Law or Extreme Risk Protection Order (ERPO) was intended to prevent dangerous persons from buying guns and required certain background checks when guns are purchased in New York State. This law imposes penalties for the use of an illegal gun, and violations can result in a mandatory life sentence without parole.

The Red Flag Law or ERPO is intended to prevent individuals who show signs of being a threat to themselves or others from purchasing or possessing any kind of firearm. It has a procedural safeguard to better ensure that no firearm is removed without due process, while helping to prevent tragedies. This law empowers teachers, school administrators, and mental health professionals (including physicians) to help prevent shootings by pursuing court intervention.

An ERPO is a court order issued when a person may be dangerous to himself or others. It prohibits a person from purchasing or possessing guns and requires the person to surrender any guns he already owns or possesses. To file an ERPO, an application and any other necessary documents must be submitted to the respondent's local Supreme Court. That same day, the judge will review it and decide if an ERPO should be issued, and, if granted, police will immediately remove all firearms from the respondent and bar them from purchasing any additional guns. A hearing for the individual will be scheduled for 3–10 days after the application is filed.

Healthcare organizations should have a policy related to who can submit such a request, and facilities should have a policy in place to address service of such an order by law enforcement upon admitted patients. For more information, visit **ny.gov/RedFlag.**

Mental Health Law Duty to Report

NY Mental Health 9.46 provides that a mental health professional (psychiatrists, psychologists, LCSWs, NPs, and PAs) must report to the Director of Community Services (DCS) the reasonable judgment of the mental health professional that a patient is likely to do serious harm to themself or others with a gun. They are not required to report if it would increase the risk of harm to the professional or a target individual. The person reporting must do so in good faith, using reasonable professional judgment. In turn, the DCS must promptly send it to the New York State Division of Criminal Justice Services, and they must state specifically why the patient is a danger to themself or others. From there, the Bureau must verify if the patient is a licensed gun owner. If so, the gun license is suspended for at least 5 years, and the patient's firearms are sequestered.

The *Tarasoff* Warning

In New York, physicians need to know there is also a warning that can be made by a medical professional to a potentially endangered person. This is based upon the *Tarasoff* case in California, where a patient told a mental health provider that he intended to kill someone and in fact did so without the endangered person being warned. The case went to court, and the ruling supported the notion that one could warn an endangered party of the threat from the person who makes such a statement. New York and many other states also adopted

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Emerging from COVID: **Immunity Update**

President Biden recently announced that, effective May 11, 2023, he will end the national emergency and public health emergency declarations arising from the COVID-19 pandemic. This raises an important question for healthcare practitioners and facilities: When will the immunity provided by the Federal Prep Act for the administration of covered countermeasures against COVID-19 terminate? As it presently stands, the immunity will continue through October 1, 2024.[1]

The question of how broadly or narrowly the Prep Act immunity will be interpreted by the courts continues to be the subject of appeals nationwide. Currently, several appeals are pending in the Second Circuit, the Court of Appeals for federal litigation in the State of New York. Circuit courts across the country have or will determine whether the Prep Act completely preempts state court actions arising out of the administration of covered countermeasures against COVID-19. As of writing, five of the 11 circuit courts have determined that the Prep Act does not completely preempt these claims and remanded the cases for litigation in state court. There, the Prep Act immunity remains a defense, but it does not preclude litigation of the case in state court, as defendants have urged.

Emerging from COVID: **Immunity Update**

The other source of immunity for care provided during the pandemic is the New York State Emergency Disaster Treatment Protection Act (EDTPA), enacted on April 3, 2020 and repealed effective April 6, 2021. Litigation regarding the EDTPA has focused on the scope of the immunity granted and whether the repeal was retroactive when passed in 2021. The latter question was recently answered in the negative by one of the four appellate divisions in New York State.[2] It remains to be seen if the other three appellate divisions will concur. The scope of the immunity that will be afforded under the EDTPA, and the requisite causal relationship between COVID and the alleged departures, remains an open question.

We have yet to see the full volume of COVID cases that will be defended based on EDTPA immunity. With the two-and-a half-year statute of limitations applicable to medical malpractice cases, and the executive order tolling the statute of limitations between March 20, 2020 and November 3, 2020, there is still time for plaintiffs to file medical malpractice actions arising from treatment during the EDTPA immunity period of April 3, 2020–April 6, 2021.

The medical malpractice cases subject to an immunity defense that we have seen thus far include: (1) allegations of failure to supervise/monitor/care for patients due to inadequate staffing; (2) failure to timely diagnose cancer due in part to the limitations of telemedicine and the lack of in-person treatment; (3) interruption in the continuity of care due to lack of in-person treatment; (4) delay in surgery due to executive orders prohibiting elective surgeries and limiting non-COVID hospital care; and (5) failure to document and maintain appropriate medical records due to time constraints and COVID demands. Defendants have had some successes in dismissing cases based upon immunity, but many courts are holding off on dismissal pending further development of the facts through discovery. Suffice it to say that movants should make every effort to demonstrate precisely how COVID impacted the care alleged to constitute a departure.

As more decisions are rendered and additional cases are commenced, we will be better able to assess how the federal and state courts will apply COVID immunity in medical malpractice cases. Stay tuned for future updates.

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1. The Eighth Amendment to the HHS Declaration providing PREP Act immunity was issued on August 4, 2021.
2. *Ruth v. Elderwood* 209 AD3d 1281 (4th Dep't. 2022).

‹ Healthcare and Firearms: What the New York Physician Needs to Know, continued from page 3

that rule. If a mental health professional fails to report to the DCS, there may be potential liability, as we saw in both the *Davis* and *Tarasoff* cases.

In this age, there are an insufficient number of psychiatrists and other mental health workers to make such reports. As a result, many family practitioners and other physicians may be treating patients with psychiatric disorders using psychotropic medications. Often, they are relatively uncomfortable doing so due to the lack of psychiatric training or even familiarity with the medications used. The duties just discussed, and the liability for failure to warn or provide appropriate information to the DCS, can create liability for those physicians.

> **As a result, many family practitioners and other physicians may be treating patients with psychiatric disorders using psychotropic medications.**

Liability Risk for Failure to Report: The *Davis* Case

When considering whether to report an at-risk patient under New York law, physicians should consider the 2015 Court of Appeals case of *Davis v. South Nassau Community Hospital*. In the case of *Davis*, a female patient came to the emergency department (ED) of the hospital with severe pain, and she was administered Ativan and Dilaudid. She left the ED 1 hour after receiving both those medications, driving her own car. She was not given any warnings that she would be under the effect of the medications for hours. While driving, she crossed the double yellow line of the highway and hit a bus driven by Mr. Davis, who was seriously injured as a result. A lawsuit was commenced against the facility for failing to warn the patient about the effects of the drugs she had received.

Although the case was dismissed by the lower court, an appeal was made to the appellate court, where it was again dismissed. It was then appealed to the Court of Appeals, the highest court in New York. The court, to the surprise of many, overturned the dismissals of the case brought by Mr. Davis. This Court found third-party liability for the hospital because the emergency physician failed to warn the patient of the side effects of the drugs the patient was given. Thus, the accident in which the patient injured Mr. Davis was reasonably foreseeable by the failure of the hospital employees to warn the patient that she should not drive under the effects of the medications given, as she could injure herself or an unrelated third party by driving impaired.

> **This Court found third-party liability for the hospital because the emergency physician failed to warn the patient of the side effects of the drugs the patient was given.**

While the premise of foreseeable risk has not been extended to cases involving firearms, physicians should bear in mind the foreseeable risk of injury that could occur when considering whether to report a patient whose mental instability could lead to violence against others.

Other Considerations

Facilities and practices should work in coordination with their local law enforcement agencies to develop a policy and procedure to address circumstances involving firearms. For example, when a patient comes to the emergency department with a weapon that is obvious or even hidden, it is important for the safety of everyone to know how to appropriately handle the situation. All staff need to be educated on this new policy and procedure.

Conclusions

Physicians have a responsibility to evaluate whether their patients pose a risk of harm to themselves and others. When those risks are associated with firearms, the risk should be promptly reported to the appropriate authorities. However, from a risk management perspective, it is also important for healthcare providers to avoid considering and treating patients who are mentally ill like criminals, as social stigma can

reduce the likelihood that they will ask for and receive the psychological help they need.

Your risk management strategies should include reviewing your policies and procedures with counsel for both compliance with current law and to keep abreast of the pending litigation associated with patient access to guns and the prohibitions of firearms in places where healthcare is offered.

Providers should assess policies and procedures regarding guns arriving with patients, visitors, and vendors at security and other entrance points, including ambulance bays, and evaluate policies for the service of an ERPO, including who will be responsible for reviewing and implementing the service of orders within the organization.

When considering your reporting requirements, thorough documentation in the patient's medical record, along with steps performed to notify the appropriate authorities of potential risks, will strengthen your defense to any claim that you failed to take appropriate steps to warn others. Further, it is crucial to have a policy in place to notify other members of the healthcare team who may encounter a potentially dangerous patient. This policy should include having an action plan in place in the unfortunate event one is needed. By adopting these recommendations into a well-rounded risk management program, the risk of patient, staff, and third-party injury is reduced.

The Risk Management Department of MLMIC Insurance Company, together with the attorneys at Mercado May-Skinner, LLP, offer educational programs and presentations that specifically address the NY SAFE Act. These programs are provided to MLMIC policyholders throughout New York State and offer guidance designed to manage the risks and reduce the exposures presented by this law, all at no additional cost to our policyholders. For additional resources, please contact the MLMIC Risk Management Department or the attorneys at Mercado May-Skinner, LLP.

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FROM THE MLMIC INSIDER

The MLMIC Insider provides ongoing and up-to-date news and guidance on important events and announcements that affect the practices of our insured physicians and other healthcare providers.

If you are interested in receiving informational posts such as the following, please be sure to sign up to receive MLMIC's *Healthcare Weekly*, the latest MLMIC Insurance Company news, and links to relevant and valuable industry articles.

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10 Tips for Integrating Telehealth into Medical Practices

MLMIC outlines guidance to promote a positive telehealth experience for both patient and physician.

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Discussing Mental Health with Patients

Given the prevalence of mental illness in America, it's critical to discuss and screen for concerns during clinical interactions.

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CASE STUDY:

A Disastrous Outcome, Despite Appropriate Treatment

A 38-year-old male with a history of depression, violent behavior, assault, and alcohol and drug abuse was brought to the emergency department (ED) of a MLMIC-insured hospital after his wife called the police when she suspected he might be suicidal due to the break-up of their marriage. She had an Order of Protection in place against him, which had recently expired. The patient was evaluated by the ED psychiatric social worker, who determined that, while he was anxious, he did not seem to be suicidal or in need of inpatient treatment. As such, the patient was discharged with instructions to be seen by the MLMIC-insured psychiatrist.

The psychiatrist saw the patient 1 week later and found him depressed and filled with despair, hopelessness, and jealousy. He expressed anger about his custody issues and the loss of his job when police questioned him at work regarding a prior assault on his wife. Although the patient admitted to chemical dependency, he appeared to be sober and denied suicidal or homicidal ideation. Our insured diagnosed him with chemical dependency and anti-social and narcissistic traits. He prescribed Lexapro and Seroquel and referred the patient to a social worker.

> **Although the patient admitted to chemical dependency, he appeared to be sober and denied suicidal or homicidal ideation.**

Two weeks later, the patient returned to the ED with extreme depression and advised that he could not afford his medication and therefore had never started it. He was admitted to the hospital and seen by another physician, who noted his anxiety, poor hygiene, and lack of sleep. While the patient had no homicidal ideation, he was found to suffer from suicidal ideation as he expressed his plan to shoot, hang, or stab himself to death. During his admission, a family meeting was held with the patient, his wife, the hospital social worker, and a nurse. It was recommended that the couple live apart and undergo marital therapy.

The following day, the patient was again seen by our insured psychiatrist, who noted that he was now taking Lexapro and Seroquel for depression and anxiety. The patient was discharged, though his prognosis was guarded as he did not exhibit much insight into his relationships, including his interactions and behavior with his wife and children. At the time of the discharge, the patient was not deemed suicidal or homicidal.

The patient was seen by the psychiatrist 1 week later as an outpatient. The physician felt the patient was compliant with his medications, provided him with sufficient refills, and referred him to a therapist to continue outpatient therapy. By this point, the patient was diagnosed with bi-polar disorder.

The patient was subsequently seen by his new therapist and believed that his diagnosis of bi-polar disease, as well as a prior failed marriage and problems in his current marriage, explained his prior behavior. At this point, it appeared that his wife wished to move on with her life without him, and he advised of his suspicion that she was dating. At this meeting, he willingly discussed his problems and expressed hope for the future. Although the future of his marriage was uncertain, the therapist's plan was to aid the patient in dealing with his

depression, set employment goals, and encourage him to be more social and involved with his children. She believed the patient was compliant with his medications at that time.

The patient returned for another session 1 week later and appeared enthusiastic about his future with his wife and children. The therapist felt that he was compliant with his medications. An appointment was made for the patient and his wife to return in 2 days; however, the appointment was canceled when the patient's wife did not confirm.

The day prior to the patient's next scheduled appointment, the patient went to the family home, where he stabbed his wife to death. He next went to their babysitter's home, where he raped her. The babysitter then went to a friend's home while the patient sat outside in his truck, asking for a gun. The friend provided the patient with a rifle, which he later used to kill himself.

An action was brought on behalf of the deceased husband and wife for their two minor children alleging failure to formulate an appropriate discharge plan for the plaintiff-decedent; discharging him with prescriptions for Lexapro and Seroquel despite his history of being noncompliant with his medications; discharging the plaintiff-decedent despite the fact that his prognosis was guarded in light of his recent history of suicidal and homicidal ideation; and failing to refer him for outpatient treatment and evaluation to assure his compliance with his medications.

This case was reviewed by expert psychiatrists, who concluded that it was overall defensible as the plaintiff-decedent had agreed to a discharge plan and, following his discharge, kept his appointments with the psychiatric social worker who noted that he was doing well. The psychiatrist had insight into the patient's problems and agreed to continued psychiatric care on an outpatient basis. The murder/suicide occurred 3 weeks after his hospital discharge, and there was nothing in his outpatient treatment indicating that he would commit this crime. In addition, the patient's wife had participated in a family meeting, at which time she agreed to work on the marital issues and did not object to the discharge plan.

The case was tried to conclusion, and a swift verdict was rendered in favor of the MLMIC-insured psychiatrist and hospital. The jury unanimously found that it was not a deviation from good and accepted standards of psychiatric practice to discharge the patient following an approximately 6-day admission for depressive/bi-polar disorder. The plaintiff's counsel did not pursue an appeal of this matter, and the case was closed upon entering the judgment.

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