

## Understanding The Doctrine of Informed Consent

By Kim M. Ruder and  
Samatha T. Lemery

As litigators and advocates for physician clients facing medical malpractice claims, as well as attorneys who often counsel and advise physician-based medical practices on the “best practices” to invoke in order to avoid becoming a defendant in a medical malpractice suit, it is important that we help our clients to understand the duties they owe their patients. These duties go beyond diagnosing medical conditions and prescribing proper treatments. One such duty, the parameters of which continue to evolve and become more refined — and perhaps more confusing — through litigation, is the duty to facilitate the patient’s informed consent.

The duty of eliciting informed consent, in its most basic form, is the duty inherent in the patient-physician relationship to properly and fully advise a patient of the risks associated with a particular procedure. With this information, the patient can decide what course of treatment is best for him or her. In order to be a proper counselor, advisor and defense attorney, lawyers should fully understand the intricacies of their own jurisdictions’ informed consent laws, which can vary widely from state to state.

*continued on page 8*

## Health Field Workers Upset by Mandatory Flu Inoculation Rules

By Janice G. Inman

The call for health care workers to get inoculated against the latest expected flu viruses is an annual event, happening just about this time every year, at the beginning of flu season. Health care providers are exposed to thousands of already vulnerable patients whose immune systems may be compromised, so it makes sense that they should be urged to take all the precautions they can to avoid infecting their charges. About 50% (give or take) generally opt not to.

Normally, health care workers are allowed to decide for themselves whether they will get a flu shot, but this year is different. One state has made inoculation against the H1N1 and other strains of flu mandatory, and several hospital systems have done the same. Those personnel who would have voluntarily gotten the inoculation may have few beefs with these policies, but many of those who would have chosen not to do so — along with other groups and individuals who see the new rules as an impingement on personal liberty — are up in arms.

### NEW YORK’S RULE

Part 66 of the Codes, Rules and Regulations of New York was amended in August of this year by the addition of Subpart 66-3, requiring annual flu vaccinations for almost all health care facility personnel. (Full name: Title 10, Subpart 66-3 Regulation for Hospitals, Diagnostic and Treatment Centers Licensed Under Article 28, Home Care Services Agencies Licensed Under Article 36 of the PHL, Hospice Programs Certified Under Article 40 of the PHL and County Health Departments.) The rule is not a one-year emergency change in response to the H1N1 virus (commonly referred to as swine flue). It is an ongoing rule change that will require New York’s health care facility workers to receive flu shots each year, covering whichever types of flu the federal government recommends people

*continued on page 2*

### *In This Issue*

Mandatory Flu Inoculation . . . . .	1
The Doctrine of Informed Consent . . .	1
Medical Liens . . . . .	3
Drug & Device News . .	5
Med Mal News . . . . .	7
Verdicts . . . . .	11

PRESORTED STANDARD U.S. POSTAGE PAID LANGHORNE, PA PERMIT 114
--

## Mandatory Inoculations

continued from page 1

receive inoculations for. This year, that means those affected by the New York law must get one shot for the seasonal flu as well as two more for the H1N1 virus.

The requirements of Subpart 66-3 apply to hospitals, diagnostic and treatment centers, home care services agencies, long-term home health programs and hospice programs. It does not apply to nursing homes, adult homes or adult day treatment facilities. Covered facilities are required to document that their existing staff have received their flu vaccinations by Nov. 30, and any personnel hired after that date must have these shots before they begin their employment.

The new rules apply not only to doctors and nurses, but also to anyone else in a health care facility who might come into regular contact with patients or with their health care providers, potentially passing on a flu virus to them. That means that volunteers and contract workers are included under the terms of the law. Those whose job sites are physically separate from patients and their caregivers are exempt. This category might include hospital administrators who do not visit the patient wards, cafeterias or other places where patients or health care workers convene. However, food service workers, maintenance workers and others who come into regular contact with health care providers will have to receive the same flu inoculations as direct health care providers. Some exceptions apply, as when a vaccine is medically contraindicated for a particular individual.

### THE BACKLASH

Many medical workers and their representative associations are making it clear that they are not happy with the imposition of the new flu shot requirements of the State of New York, or of individual employers.

The University of Iowa's attempt to impose a flu inoculation requirement on its employees was thrown

off schedule in September when the union representing health care workers at the university's medical facilities filed for an injunction. The parties subsequently agreed to submit the issue to a mediator. Similar legal actions have been filed in other states, including Washington, where the large health care employer, Multi-Care Health System, is trying to force its workers to get the H1N1 vaccine.

Soon after the law went into effect in New York, hundreds of health care workers marched in protest on the Capitol building in Albany, NY, carrying signs saying, "Stop selling fear! We don't need flu vaccines. My body, my choice!" and "Inmates Have More Rights Than Workers," among others. At meetings over the summer of the New York State Hospital Planning and Review Council Codes and Regulations Committee the New York State Nurses Association referred to the new rules as a "scorched earth" approach to combating the spread of influenza in health care facilities. On Oct. 9, a group of New York health care providers went to court in Washington, DC, asking the judge to order the federal government not to distribute the H1N1 vaccine. Their claim is that the swine flu vaccine was approved without the legally required testing for safety and efficacy. As part of their suit, they are asking for an injunction against New York's mandated flu inoculations. Meanwhile, a lawsuit has been filed in New York State trial court against the state's health commissioner, brought on behalf of 60,000 New York health care facility workers.

For his part, New York State Health Commissioner Richard F. Daines, M.D., is trying to encourage compliance by allaying fears and appealing to health care providers' sense of duty to their patients. In September, he released an open letter to health care workers in New York State. Its first line reads, "As health care workers, we share one of the proudest traditions of all profes-

sions: we put our patients' interests

*continued on page 4*

## Medical Malpractice Law & Strategy®

EDITOR-IN-CHIEF ..... Janice G. Inman  
EDITORIAL DIRECTOR ..... Wendy Kaplan Stavinoha  
MARKETING DIRECTOR ..... Jeannine Kennedy  
GRAPHIC DESIGNER ..... Louis F. Bartella

### BOARD OF EDITORS

DAVID M. AXELRAD ..... Horvitz & Levy LLP  
Encino, CA

CHRISTOPHER D.  
BERNARD ..... Koskoff, Koskoff & Bieder, P.C.  
Bridgeport, CT

MICHAEL D. BROPHY ..... Goldberg Segalla LLP  
Philadelphia

BARRY B.  
CEPELEWICZ, MD ..... Meiselman, Denlea,  
Packman, Carton & Eberz, P.C.  
White Plains, NY

LORI G. COHEN ..... Greenberg Traurig, LLP  
Atlanta

LINDA S. CRAWFORD ..... Linda Crawford & Associates  
New York

ERIC J. FRISCH ..... Carlock Copeland & Stair LLP  
Atlanta

AMY J. KOLCZAK ..... Owen, Gleaton, Egan, Jones &  
Sweeney, LLP  
Atlanta

WILLIAM A. KRAIS ..... Porzio, Bromberg & Newman P.C.  
Morristown, NJ

CARRIE N. LOWE ..... Webb, Zschunke, Neary &  
Dikeman, L.L.P.  
Atlanta

CONNIE MATTEO ..... Porzio, Bromberg & Newman, PC  
Morristown, NJ

ERIC PROBST ..... Porzio, Bromberg & Newman, PC  
Morristown, NJ

KEVIN QUINLEY ..... Berkley Life Sciences  
Fairfax, VA

JOHN RATKOWITZ ..... Star, Gem Davison & Rubin  
Roseland, NJ

JAMES SOKOLOVE ..... Law Offices of James Sokolove  
Newton Center, MA

CHAD STALLER ..... The Center for Forensic Economic  
Studies  
Philadelphia

DEBRA SYDNOR ..... Alston & Bird, LLP  
Atlanta

RON WERNETTE ..... Bowman and Brooke LLP  
Troy, MI

Medical Malpractice Law & Strategy® (ISSN 07477-8925) is published by Law Journal Newsletters, a division of ALM. ©2009. Incisive US Properties, LLC. All rights reserved. No reproduction of any portion of this issue is allowed without written permission from the publisher. Telephone: (877) 256-2472  
Editorial e-mail: wampolsk@alm.com  
Circulation e-mail: customercare@alm.com  
Reprints: www.almreprints.com

POSTMASTER: Send address changes to:  
ALM  
120 Broadway, New York, NY 10271

Published Monthly by:  
Law Journal Newsletters  
1617 JFK Boulevard, Suite 1750, Philadelphia, PA 19103  
www.ljonline.com



# Ethical Concerns: Medical Liens and Rights of Subrogation

## Part Two of a Two-Part Article

By J. Michael Hayes

In last month's issue, we discussed the development of federal and New York State statutory and case law regarding third-party liens against the proceeds of medical judgments. Medicare, Medicaid and Workers' Compensation programs, among others, all want reimbursement of monies they have expended on those whose medical treatments they have covered. Straightforward as this concept might at first seem, problems for the injured party's attorney can quickly develop when he or she begins trying to work out the details, amongst the interested parties, of who gets what.

### LIEN OR SUBROGATION?

Many purported "medical liens" are actually "statutory rights of subrogation," where the medical provider has the right to pursue its assignment directly against the tortfeasor. Ethical issues arise when an attorney represents an injured claimant and also agrees to pursue the "subrogation claim" of the medical provider.

Recent developments have changed the way that lien law is applied in New York State, given *Arkansas Dept. of Health and Human Services v. Ahlborn*, 126 S.Ct. 1752 (2006), and *Faso v. Doerr*, 12 NY3d 80 (2009). Medicare, Medicaid and Workers' Compensation carriers claim they are entitled to full recovery of their expenses under the lien statutes. The reality is that recent decisions in *Ahlborn* and *Fasso*, combined with New York's shift to comparative

---

**J. Michael Hayes** is an attorney in Buffalo, NY, practicing plaintiff's personal injury law. This article first appeared in the *New York Law Journal*, a sister publication of this newsletter.

negligence and itemized verdicts since the 1970s, confirm that at best, they have a right of apportionment for their "subrogation" claims.

Whether the right is a lien or subrogation affects the relationships between the co-claimants and the attorney, as well as his or her fees. If these constitute subrogation rights then the attorney is clearly representing two claimants, negotiating an aggregate settlement and taking a fee from each. A conflict arises because the attorney must reduce/assign part of the client's recovery to the insurance carrier for medical expenses. Ethically, an attorney is barred from representing more than one party where there may be a lump sum award that has to be divided/allocated.

Attorneys who pursue the personal injury claim and medical expense recovery in one action are committing an ethical violation as well as possible malpractice. Although the statute still refers to liens, attorneys practicing in this area would be best advised to treat such claims as subrogation.

### THE SYSTEM

We all know the status quo when a personal injury claim is pending after public funds have been expended for the client: Medicare claims a "superior" right to recover its medical costs (past and future) upon a personal injury recovery. Medicaid providers consider that they have a lien on the proceeds of a personal injury recovery though they reluctantly concede that the trend seems to be toward *Ahlborn* proceedings for apportionment. Workers' Compensation insurers take the position that their "lien" claims are "inviolable." They specifically assert that the carrier's lien is enforceable against the entire amount of the recovery after subtraction of attorneys' fees.

In the realm of "liens versus subrogation rights," there often is an aggregate offer, which invariably must be divided in a manner that satisfies both claimants. The attorney receives contingent compensation from both his client (the plaintiff) and the medical provider. This amounts to fees from two claims out

of the same accident, allocated from a single pool of funds. There are some schools of thought that would very strongly suggest that this arrangement constitutes a conflict of interest and is an ethical violation.

A rift seems to be developing in the private health care field over insurers' right to recover money they expended on medical costs associated with tort claims. The New York Court of Appeals just confirmed in *Fasso*, that there may be an independent claim asserted by the health care provider either joined with the personal injury action or independent of it as against the tortfeasor. The *Fasso* court recognized that "[t]he injured party's goal is to maximize recovery without regard to whether its insurer recoups any monies it expended for the plaintiff's medical bills" and the insurer cares only about its own recovery regardless of whether the insured's compensation is adequate, or even nil. The court further held that the "made whole" rule is applicable in New York. It observed that the health insurer assumes a risk of loss when it issues a policy, whereas the injured party does not willingly assume a risk of injury. As such, only after the insured had fully recovered may the insurer recover on its claim. The insured has the "priority of interests," which takes precedence over the subrogation rights of the insurer.

(This right of recovery for the private health care provider will be eliminated if the New York Senate Bill S.6068, which was recently passed, is signed into law. That bill modifies CPLR 4545 and precludes recovery by private health insurers. The bill does not, however, limit or restrict the recovery rights of Medicaid, Medicare, Workers' Compensation nor Additional Personal Injury Protection (APIP). As such, the same concerns, exposures and ethical issues that exist in the private health care recovery field will continue to exist and trouble New York attorneys and claimants regardless of whether the above bill becomes law.)

*continued on page 4*

---

## Medical Liens

*continued from page 3*

### GETTING THE PROPORTIONS RIGHT

Medical providers claiming statutory “liens” routinely demand that plaintiff’s counsel negotiate on their behalf as well as on behalf of the personal injury client. These takings from plaintiff’s personal injury recoveries are justified as a “balancing of interests” and “cost containment measures” as between the government, workers, insurers, employers and, inferentially, the plaintiff’s own attorneys. The language relative to these demands and expectations is often threatening.

The plaintiff’s attorney needs to be aware that she faces the risks of liability associated with lien resolution. When an attorney undertakes a personal injury lawsuit, she impliedly represents that she has the legal knowledge, skill, and preparation necessary to represent the client’s interests competently in that area of the law. If an attorney overpays the lien, or pays an invalid lien, he may be liable for legal malpractice; if the attorney fails to discover or pay an outstanding Medicare lien, he can be held personally liable for twice the amount of the original lien, plus interest. (*See* 42 U.S.C. §1395y(b)(2) (A)(ii-iii)). New York County Lawyers’ Association Ethics Committee Ethics Opinion 739.

The standard wisdom in the legal community has been to pay these “lienors,” save what can be retained for the client and, as a consolation, the attorney is paid his full fee on

the total recovery. At least his fee is not reduced.

However, lawyers are ethically required, “Within the Bounds of the Law” (New York Disciplinary Rule (DR) 7-102) to represent a “Client Zealously” (DR 7-101). Those Disciplinary Rules require that, while an entity may have a “claim” for a part of the injured party’s recovery, attorneys are ethically required to examine the predicates of that claim closely and may not dissipate their clients’ funds absent the claim being proven bona fide.

The Disciplinary Rules further require that an attorney “shall decline simultaneous representation if it is likely to involve the lawyer in representing different interests.” DR 5-105(a). “A lawyer who represents two or more clients shall not make or participate in the making of an aggregate settlement of or against the clients.” DR 5-106; cf. new Rules of Professional Conduct, Rule 1.8:(g). Finally, “a lawyer shall not accept compensation for legal services from other than the client.” DR 5-107. The ultimate issue is whether an attorney may include in his prayer for relief compensation for both bodily injury, pain and suffering and medical expenses that were paid not by the client but by an insurer. To find the answer, one must examine each of the “lien” statutes.

### CONCLUSION

In all these lien/subrogation statutes, the enabling legislation authorizes the medical provider to initiate its own independent action for recovery of expenses pursuant to

the principles of subrogation. However, there is no incentive for any of these subrogees to pursue their own claims. The general practice is for the injured party’s attorney, clearly representing two claimants, to voluntarily negotiate an aggregate settlement, allocate the money between those competing parties and take a fee from each. The medical provider does no work and takes no risks. However, if it and the plaintiff’s attorney work together, it recovers from the gross award and more money is available for attorneys’ fees.

The only one who comes up short in this scenario is the injured party. His personal injury recovery is reduced by the amount his attorney agrees to pay the medical provider on the subrogation claim. This is an obvious conflict of interest. As this practice has been going on for many years, a recent observation by a plaintiff’s attorney may be accurate: “Clients are not sophisticated enough to understand those issues.”

The simple conclusion is that there is both an inherent and obvious conflict of interest for an attorney to represent two claimants for independent claims arising out of the same incident, obtain a single lump sum settlement and then allocate the respective amounts while taking a fee from both clients. Attorneys would be well advised to seriously consider and analyze these issues, taking into account their own states’ laws and ethics codes.



---

## Mandatory Inoculations

*continued from page 2*

ahead of our own.” He compares the precautions medical personnel are now being asked take with those they took in response to the HIV and SARS epidemics, and says that these precedents evidence a “tradition” that should be adhered to. Dr. Daines’ open letter goes on to say:

Questions about safety and claims of personal preference

are understandable. Given the outstanding efficacy and safety record of approved influenza vaccines, our overriding concern then, as health care workers, should be the interests of our patients, not our own sensibilities about mandates. On this, the facts are very clear: the welfare of patients is, without any doubt, best served by the very high rates of staff immunity that can only be achieved

with mandatory influenza vaccination — not the 40%-50% rates of staff immunization historically achieved with even the most vigorous of voluntary programs. Under voluntary standards, institutional outbreaks occur every flu season. Medical literature convincingly demonstrates that high levels of staff immunity confer protection on those patients who cannot be or have

*continued on page 6*

# DRUG & DEVICE NEWS

## INSURER NOT OUT OF BODY PART THEFT FIASCO

A body-parts-for-cash scandal that sent three Philadelphia funeral directors to prison last year has sparked a wave of litigation in the state and federal courts, and a federal judge's recent ruling on insurance coverage promises to keep the cases alive. In a major setback for the insurer, Nationwide Mutual Insurance Co., U.S. District Judge Michael Baylson in Philadelphia rejected the argument that guilty pleas by the participants conclusively proved that all of the conduct was intentional and therefore could not be treated as negligent conduct that triggers insurance coverage.

Funeral home operators Louis and Gerald Garzone and their employee, James McCafferty Jr., have already confessed that they sold corpses to Biomedical Tissue Services, a New Jersey-based company that took bodies from funeral homes in New York, New Jersey and Pennsylvania. Among the corpses plundered was that of veteran BBC broadcaster and "Masterpiece Theatre" host Alistair Cooke. Judge Baylson determined that each of the of the lawsuits had to be individually screened to determine whether any of them contained negligence-based claims that would trigger coverage under the funeral home's policies.

## ACTOR AND WIFE WANT CASE HEARD IN DRUG COMPANY'S BACKYARD

Actor Dennis Quaid and his wife want their case against Baxter Healthcare Corp. heard in Illinois, the home of the drug company. An Illinois appellate court, however, upheld dismissal of the case because it agreed with the lower court that the proper venue for the action was California, the place where the plaintiffs' twins accidentally received an overdose of the blood thinner Heparin. These mix-ups had happened before, ostensibly because of confusing labeling of the

differing strengths of the drug. The Quaid's say that these previous similar incidents should have prompted the company to alter the labels in order to make it clearer which bottles contained the smaller doses appropriate for infants. They have asked Illinois' Supreme Court to review the dismissal. Baxter spokeswoman Erin Gardiner defended the dismissal on the basis that the overdosing occurred in California, where the plaintiffs and most of the defendants reside. The Quaid's attorney, Susan Loggans of Chicago's William Harte, disagrees: "If a plaintiff doesn't have the right to go to a defendant's home state and face what would normally be considered a hostile jury because the plaintiff knows what's best for its own case, then you'll be virtually blocking any innocent person from doing what is best for them and allowing the defendant to control where any case is filed." Loggans pointed out that the case is not being brought as one for medical malpractice (the matter has already been settled with the hospital) and is instead concerned primarily with the workings of Baxter and how their decisions concerning labeling were made. Because its employees and former employees are primarily in Illinois, this is the proper forum, she feels.

## NO RISE IN AUTISM RATES, ACCORDING TO UK'S NHS

New evidence that the MMR (Measles, Mumps, Rubella) inoculation is not the cause of the apparent rise in autism in the developed world was recently made public by Britain's National Health Service (NHS). In September, the NHS conducted a survey of Britain's households to learn how many adults in the population could be classified as having an autism spectrum disorder. In testing the members of about 4,000 households, the researchers found that one person in 100 over the age of 18 had such a disorder — about the same as the

proportion of young children in the British population diagnosed with autism or asperger's syndrome. Because the current MMR shot became available only in the early 1990s, the study bolsters the position of those who refute any relationship between MMR inoculations and the apparent increase in autism, pointing instead to an oft-cited alternative reason for the supposed epidemic: greater understanding of the symptoms of autism that has led to increased diagnosis. A pdf of the study's results can be accessed at: [http://www.ic.nhs.uk/webfiles/publications/mental%20health/mental%20health%20surveys/Autism\\_Spectrum\\_Disorders\\_in\\_adults\\_living\\_in\\_households\\_throughout\\_England\\_Report\\_from\\_the\\_Adult\\_Psychiatric\\_Morbidity\\_Survey\\_2007.pdf](http://www.ic.nhs.uk/webfiles/publications/mental%20health/mental%20health%20surveys/Autism_Spectrum_Disorders_in_adults_living_in_households_throughout_England_Report_from_the_Adult_Psychiatric_Morbidity_Survey_2007.pdf).

## PERSONALIZED MEDICAL TREATMENT METHOD HELD PATENTABLE

In a closely watched case that is expected to aid the field of personalized medicine, the Federal U.S. Circuit Court of Appeals has ruled that a medical treatment method is patentable. The Sept. 16 opinion in *Prometheus Laboratories Inc. v. Mayo Collaborative Services* reversed a lower court's ruling invalidating Prometheus' patents that cover methods of adjusting the dosage of certain drugs, used to treat autoimmune diseases such as Crohn's disease, depending on a patient's particular metabolism. The district court had found that the correlations between the effectiveness and toxicity of the drug for a patient and the patient's metabolites were natural phenomena resulting from a natural body process.

## SCRUB TECH WHO TAMPERED WITH SYRINGES PLEADS GUILTY

Former Colorado surgery scrub tech Kristen D. Parker pleaded guilty in September to charges of product tampering and other drug

*continued on page 6*

---

## Drug & Device

continued from page 5

charges based on her theft of syringes containing the painkiller Fentanyl Citrate while she was performing her professional duties at Colorado's Rose Medical Center. During her guilty plea, Parker admitted to injecting herself with the drugs and then replacing the liquid in the syringes with saline solution, leaving the altered syringes for use on patients. Several of those patients blame Parker for the fact that, like her, they now have hepatitis C. Parker, who could have faced life in prison for her crimes, is to be sentenced to a 20-year term.

### FIRST FOSOMAX CASE ENDS IN MISTRIAL

The first trial alleging jawbone deterioration from the use of the osteoporosis treatment drug Fosomax has ended in a mistrial. The jurors who heard the case in U.S. District Court in Manhattan deadlocked in September after a week of deliberation. At that point, they indicated that they could not come to a con-

sensus on the issues of negligence and failure to warn. The plaintiff, Shirley Boles, is a retired Florida resident who claimed that her use of the drug over a period of several years caused her to develop jawbone necrosis, a painful and irreversible condition. More than 1,000 similar cases are still awaiting trial.

### FDA APPROVES DONOR SCREENING TEST FOR ANTIBODIES TO HIV

The U.S. Food and Drug Administration (FDA) in September gave its approval to the Abbott Prism HIV O Plus assay, a screening tool designed to detect the presence of certain antibodies to HIV. It tests for antibodies to HIV type 1, groups M (the most common subgroup of the virus in the United States) and O, and HIV type 2. The assay is licensed to screen donated blood and blood specimens, as well as donor organs from both living and deceased donors. When positive results are obtained through this new screening tool, supplemental tests are required.

### VITAMIN'S HEALTH CLAIMS CHALLENGED

The Washington-based Center for Science in the Public Interest (CSPI), a nonprofit health advocacy group, is suing the German drug giant Bayer for allegedly making false claims concerning its Men's One A Day multivitamin. The group says that Bayer mislead consumers into believing that the selenium in the vitamin could reduce the risk of prostate cancer.

In a statement, Bayer said that it has "based a portion of the promotion for One A Day Men's Formula on the U.S. Food & Drug Administration's permitted qualified health claim that 'Selenium may reduce the risk of certain cancers.' ... The FDA changed its permitted qualified health claim earlier this year and Bayer is in the process of revising the packaging and promotional materials for its One-A-Day Men's and One-A-Day Men's 50+."



---

## Mandatory Inoculations

continued from page 4

not been effectively vaccinated themselves, while also allowing the institution to remain more fully staffed.

### NOT UNPRECEDENTED

In addition to the medical community, many in the general public are also concerned about their government's ability to require inoculations. Although they might be very happy to know that their medial caregivers are less likely to pass on the H1N1 virus to them, they worry that laws like this make it easier for government to take the next step and say, "Every state resident [whichever state that may be] must be inoculated." However, allowing the current laws and hospital rules to go unchallenged will not necessarily help prevent this, as there is precedent for just such a mandate.

In *Jacobsen v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905), the defendant objected to a state-wide law allowing local authorities to require all citizens over the age of 21 to be vaccinated when those authorities deemed it necessary. In accordance with the statutes, the board of health of Cambridge, MA, adopted a regulation requiring its adult citizens to receive smallpox vaccinations. The defendant claimed that compulsory vaccination rules were an assault on his liberty and, literally, an assault on his person. The state court nonetheless found him guilty of disobeying the law and fined him the amount set forth in the statutes: \$5. The appeal went all the way to the U.S. Supreme Court.

The Supreme Court noted that "the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in

all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good." In deciding that the Massachusetts law should stand, and that the defendant had no protected liberty interest in defying it, the Court concluded:

We are unwilling to hold it to be an element in the liberty secured by the Constitution of the United States that one person, or a minority of persons, residing in any community and enjoying the benefits of its local government, should have the power thus to dominate the majority when supported in their action by the authority of the state. While this court should guard with firmness every right appertaining to life, liberty, or property as secured to the individual by the supreme law of the land, it is of the last importance that

continued on page 12

## GRANTS TO BE AVAILABLE FOR STUDY OF MED-MAL SYSTEM ALTERNATIVES

President Barack Obama has ordered the Department of Health and Human Services to make \$25 million available to groups that will study alternatives to our nation's current medical liability system. Noting that medical malpractice insurance premiums account for only a small percentage of the costs of running a medical practice, the President's memorandum to the Secretary of HHS nevertheless pointed out that many physicians report they are practicing defensive medicine in order to avoid medical liability, leading to increased medical costs for all American medical care consumers. "We should explore medical liability reform as one way to improve the quality of care and patient-safety practices and to reduce defensive medicine," said the President. The grants are to be made available to states, localities and health care provider systems wanting to study alternatives to our current medical liability system. In accordance with a "fact sheet" issued in conjunction with the letter to the Secretary of HHS, grants of up to \$3 million may be made, and one-year planning grants of up to \$300,000 will also be made available. Decisions on grant awards are slated to be announced early in 2010.

The American Association for Justice (AAJ — formerly the American Association of Trial Lawyers) on Sept. 17 issued a statement in response to the President's letter to HHS. The Association, noting that 46 states have already passed some form of tort reform measure, turned its attention to the limits these laws have placed on injured patients, stating, "It is critical that these demonstration projects preserve Americans' 7th Amendment right to a trial by jury. The details matter significantly, but any efforts to limit patients' rights are not acceptable. Promoting greater patient safety and reducing

preventable medical errors are tenets doctors, attorneys, hospitals, and all Americans can support."

The AAJ has also launched an advertising campaign aimed at telling lawmakers that limitations on medical malpractice suits and recoveries are unfair to injured patients and will not lower the costs of medical care. The first phase of the campaign, focused on Washington-area news providers, points out that 98,000 people die each year due to preventable medical errors. "That's like two 737s crashing every day for a whole year," says the ad. The advertisement concludes by asking, "Would we blame the passengers or the airlines?" In conjunction with the publication of the new ads, AAJ President Anthony Tarricone explained, "This new ad campaign gives Congress 98,000 reasons why they should put patients' health first — before the profits of insurance companies. If we work to improve our health care system and reduce medical errors — rather than strip people of their rights — there would be far fewer victims that need legal recourse."

## NEW DEFENDANTS CHARGED IN INSURANCE FRAUD CASE

In September, seven hospital workers, all of them employed in the Bronx at either the Lincoln Medical and Mental Health Center or Jacobi Hospital, were accused of accepting bribes from an attorney in exchange for confidential medical information that the lawyer allegedly used to solicit clients in a no-fault insurance scam. According to a release from New York's Office of the Attorney General, "The information was then allegedly used by others to lure patients into receiving unnecessary treatment and then submit over a million dollars in phony personal injury claims to insurance carriers." The seven medical personnel are each charged with receiving a bribe in the third degree, a Class D felony, and with the misdemeanor charge of official misconduct. These

seven join several medical care personnel arrested in July in connection with the same alleged plot. According to the original 147-count indictment filed in Bronx Supreme Court on July 8, the scheme was run by Queens resident Daniel Levy, who is affiliated with two medical clinics in the Bronx. These clinics allegedly provided unnecessary care to victims of minor traffic accidents referred to the clinics after information was obtained about them through their confidential medical records. In response to the news that charges had been brought against these additional defendants, Rose Gill Hearn, Commissioner of the New York City Department of Investigation, said, "Undercover investigators from DOI [New York City's Department of Investigation] and the state Attorney General's Office exposed this con game for what it was — as charged, professionals selling their integrity to exploit confidential patient information for personal gain."

## FERTILITY CLINIC MIX-UP LEADS TO SUIT

A suit has been filed against a San Francisco fertility clinic and against several health care providers working there by a woman whose embryos were accidentally fertilized with sperm from someone other than her husband. When the mistake was discovered, the Laurel Fertility Clinic destroyed the fertilized embryos, without the couple's consent. According to the plaintiff couples' lawyer, Nancy Hersh, founding partner at San Francisco's Hersh & Hersh, the woman whose embryos were disposed of "believes one of the reasons they destroyed the embryos without her permission and against her wishes and in violation of the contract is because they didn't want to have to notify the gentleman whose sperm they had used of the mistake." The suit, filed in San Francisco Superior Court, does not allege medical malpractice, but instead claims the clinic and its personnel are guilty of common law negligence and of breach of contract.

*continued on page 8*

---

## Med Mal News

continued from page 7

It seeks \$80,000 in actual damages, plus punitive damages and damages for emotional distress.

### ARIZONA ABORTION RESTRICTION LAW GETS RESTRICTIONS OF ITS OWN

A preliminary injunction has been issued preventing the State of Arizona from enforcing some of the pro-

visions of its new abortion informed consent legislation, signed into law in July. The law requires physicians to inform women, in person, of the nature of the procedure and imposes a 24-hour waiting period between the time a woman receives this information and the time the procedure can be performed. It also requires minors to obtain notarized permission from their parents before an abortion can take place. Although the 24-hour waiting period

was left in place, the court hearing the challenge to the new law enjoined enforcement of the requirement that only physicians provide informed consent; other personnel can now provide the information to women seeking abortions, and they may do so over the telephone. Similarly, the requirement of a notarized note from parents of minors was put on hold until notary confidentiality can be ensured.

—♦—

---

## Informed Consent

continued from page 1

### THE RIGHT POINT OF VIEW

As a general proposition, physicians understand that they have a duty to inform their patients of the risks associated with medical treatment. Physicians, who clearly possess greater medical knowledge than their patients, understand risks and are able to weigh those risks based on their knowledge, training and experience in medicine. However, patients often bring their own set of priorities to the decision whether to embark on a specific course of medical treatment or to undergo a particular procedure. The question becomes, in advising our clients on the duty of informed consent, whose opinion matters most? Do we tell physicians that the duty to disclose information is measured from the patient's perspective, from the physician's perspective, or both?

As you might expect, the short answer is, "It depends." Interestingly, some states measure the duty of informed consent from the physician's point of view while other states

measure the duty from the patient's point of view. To further confuse the boundaries of the duty, there is even a third category of states that measure the duty from both — a "hybrid" form of the duty, so to speak.

### FROM THE DOCTOR'S PERSPECTIVE

In the states that measure the duty of informed consent from the physician's point of view, the duty becomes a question of professional standards. Some states in this category focus on the customary practices in the relevant community, while others focus on what a reasonably prudent physician would do. For instance, in Arkansas adequate disclosure of the risks of a procedure is measured by the customary practice of the physicians in the community in which the medical care provider practices, or in a similar community. *Brumley v. Naples*, 320 Ark. 310, (1995). In fact, this standard of care applies in Arkansas even in a case arising from the physician's failure to disclose certain known risks to the patient. *Fuller, Adm'x v. Starnes*, 268 Ark. 476 (1980).

In Idaho, they apply a similar standard, as illustrated by the case of *Sherwood v. Carter*, 119 Idaho 246 (1991). In *Sherwood*, the patient brought an action against her physician, claiming that he performed a biopsy on her without her informed consent. The trial court entered judgment on the jury's verdict in favor of the physician, and the patient appealed.

When the case reached the Idaho Supreme Court, the court first

looked at the state's statute concerning the sufficiency of informed consent, Idaho Code § 39-4304, which states:

Sufficiency of consent. — Consent for the furnishing of hospital, medical, dental or surgical care, treatment or procedures shall be valid in all respects if the person giving it is sufficiently aware of pertinent facts respecting the need for, the nature of and the significant risks ordinarily attendant upon such a patient receiving such care, as to permit the giving or withholding of such consent to be a reasonably informed decision. Any such consent shall be deemed valid and so informed if the physician or dentist to whom it is given or by whom it is secured has made such disclosures and given such advice respecting pertinent facts and considerations as would ordinarily be made and given under the same or similar circumstances, by a like physician or dentist of good standing practicing in the same community. As used in this section, the term "in the same community" refers to that geographical area ordinarily served by the licensed general hospital at or nearest to which such consent is given.

There appeared to be some ambiguity in this statute, whose first and second sentences seemed to offer two different standards. In fact, the *Sherwood* court noted that the

continued on page 9

---

**Kim M. Ruder** is of counsel with the law firm of Carlock, Copeland & Stair, LLP in Atlanta. Her litigation practice is focused primarily on medical malpractice, general liability and trucking and transportation law. **Samantha T. Lemery** is an associate with the firm. Her practice is focused in the areas of medical malpractice, general liability and products liability.

## Informed Consent

continued from page 8

language of the statute had “created substantial confusion among the members of the trial bench and bar as a result of what appears to be two inconsistent standards, *i.e.*, ‘patient-based’ [in the statute’s first sentence] versus a ‘physician-based’ [in the statute’s second sentence] standard of disclosure.” However, the court found the statute not inconsistent after conducting an in-depth review of the first sentence of § 39-4304. It states that consent to medical treatment is valid if “the person giving it is sufficiently aware of pertinent facts respecting the need for, the nature of and the significant risks ordinarily attendant upon *such a patient receiving such care* as to permit the giving or withholding of such consent to be a reasonably informed decision.” (Emphasis added.)

With this language in mind, the court looked up the word “ordinary” in Webster’s Seventh Collegiate Dictionary and found that it means “routine, normal.” It next turned to Black’s Law Dictionary (6th ed.), which defines “ordinary” as “usual, common, customary, reasonable, not characterized by peculiar or unusual circumstances.” Webster’s Seventh Collegiate Dictionary also defines “ordinarily” as “in an ordinary manner or to an ordinary ... degree,” and the word “such” as “of the same class, type or sort: similar.” Taking these definitions together, the court then found:

Applying the ordinary and usual meanings of the words used in I.C. § 39-4304, the phrase ‘such a patient’ can logically and reasonably be interpreted to mean a patient within the class of similarly situated patients. As such, the language in the first sentence of I.C. § 39-4304 can logically be interpreted as creating an objective standard of disclosure based on reasonableness with regard to patients who are similarly situated. To interpret the language in the first sentence to be a subjective ‘patient-

based’ standard of disclosure is contrary to the ordinary, common and usual meaning of the words used. Furthermore, and perhaps more important, interpretation of the first sentence as creating a ‘patient-based’ subjective standard clearly conflicts with the express language contained in the second sentence of I.C. § 39-4304.

Thus, the court determined that the physician-based, rather than patient-based, standard was applicable in Idaho.

### THE PATIENT-BASED STANDARD

Some states use a patient-based standard of informed consent and measure the extent of the duty by deciding what information a reasonable patient would require to intelligently make his or her treatment decision. For example, the courts in Alabama appear to favor an objective, rather than subjective, patient-based measure “based on what a reasonable person in the patient’s position would have done had the information been disclosed by the practitioner.” *Craig v. Borcicky*, 557 So.2d 1253 (1990) (citing *Fain v. Smith*, 479 So.2d 1150 (1985)).

In 1988, New Jersey abandoned its physician-based standard of disclosure in favor of a more patient-based one. The primary reasons for the change were enunciated by that state’s highest court in *Largey v. Rothman*, 110 N.J. 204 (1988), a case in which the trial court in a medical malpractice action had instructed the jury that the defendant physician was required to tell his patient “what reasonable medical practitioners in the same or similar circumstances would have told their patients undertaking the same type of operation.” By answer to a specific interrogatory on this point, the jurors responded that defendant had not “fail[ed] to provide [the plaintiff] with sufficient information so that she could give informed consent.” On appeal, New Jersey’s Supreme Court reversed, stating for its reasons:

The jurisdictions that have rejected the “professional” standard in favor of the “prudent patient”

rule have given a number of reasons in support of their preference. Those include:

1) The existence of a discernible custom reflecting a medical consensus is open to serious doubt. The desirable scope of disclosure depends on the given fact situation, which varies from patient to patient, and should not be subject to the whim of the medical community in setting the standard.

2) Since a physician in obtaining a patient’s informed consent to proposed treatment is often obligated to consider non-medical factors, such as a patient’s emotional condition, professional custom should not furnish the legal criterion for measuring the physician’s obligation to disclose. Whether a physician has conformed to a professional standard should be important [only] where a pure medical judgment is involved, *e.g.*, in ordinary malpractice actions, where the issue generally concerns the quality of treatment provided to the patient.

3) Closely related to both 1) and 2) is the notion that a professional standard is totally subject to the whim of the physicians in the particular community. Under this view a physician is vested with virtually unlimited discretion in establishing the proper scope of disclosure; this is inconsistent with the patient’s right of self-determination. As observed by the court in *Canterbury v. Spence* [464 F.2d 772 (D.C. Cir.), cert. den., 409 U.S. 1064 (1972)]: “Respect for the patient’s right of self-determination demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.”

4) The requirement that the patient present expert testimony to establish the professional standard has created problems for patients trying to find physicians willing to breach the

continued on page 10

## ***Informed Consent***

*continued from page 9*

“community of silence” by testifying against fellow colleagues. [D. Louisell and H. Williams, *Medical Malpractice* § 22.08 at 22-23 (1987) § 22.12 at 22-45 to -47 (footnotes omitted).]

Taken together, these reasons supporting the adoption of the “prudent patient” standard persuaded the New Jersey Supreme Court that the time had come “for the state to abandon so much of the decision by which this Court embraced the doctrine of informed consent as accepts the “professional” standard.” Thus, the court overruled precedent that had adhered to the physician-based standard for determining adequate disclosure for a finding of informed consent.

### **ALTERNATIVE STANDARDS**

California uses a modified physician-based standard, described in *Cobbs v. Grant*, 8 Cal.3d 229 (1972). There, the California Supreme Court, in discussing on appeal a physician’s duty to inform, said that a doctor does not need to disclose risks when the patient requests that he not be so informed. Disclosure also need not be made if the procedure is simple and the danger remote and commonly appreciated to be remote. Finally, a physician does not have to disclose a risk that goes beyond what the medical community requires when the physician can show the disclosure would upset the patient to the point that the patient would not be able to decide on a treatment without the influence of passion.

In other states, other hybrid forms of the standard are used. For instance, in Georgia, for certain procedures, a physician must inform a patient of “the material risks generally recognized and accepted by reasonably prudent physicians of infection, allergic reaction, severe loss of blood ... which, if disclosed a reasonably prudent person in the patient’s position, could reasonably be expected to cause such prudent person to decline such proposed surgical or diagnostic procedure

on the basis of the material risk of injury that could result.” O.C.G.A. § 31-9-6.1(a)(3). As shown, both the physician’s perspective and the patient’s perspective are taken into consideration.

***Thoroughly prepare your clients to testify in depth regarding how they discussed (and documented) the pros and cons of a particular medical procedure with their patients.***

### **CONCLUSION**

The advantages and disadvantages of the physician-based and patient-based standards are fairly clear. On the one hand, the physician-based standard appears to leave less room for a patient’s particular desires and circumstances and focuses less on emotion and more on technical medicine. This standard is more concise and less susceptible to hindsight arguments, and it would appear to combat the often-made argument of plaintiffs that they would have chosen a different treatment option if given more information. On the other hand, the states that employ a patient-based standard are more sympathetic to the patient’s needs. The patient-based standard certainly gives more deference to the self-determination of each individual patient, protecting them from the type of complicated or otherwise unintelligible “informed consent” that leaves them, ultimately, uninformed. Yet the trappings of hindsight are sure to become an issue in a case when the standard is based on what a reasonable person would have done had the physician disclosed the information. As for the hybrid

standard, it seems to produce both the advantages and disadvantages of the other standards.

In terms of counseling our defendant clients and our physician-based medical practices yet to be sued, the advice to the medical malpractice practitioner is simple — do not overlook or misapply the duty of informed consent. Ensure that the method your clients employ in obtaining informed consent conforms to the law of the jurisdiction in which the professional practices medicine. Physicians in a patient-based jurisdiction need to know that what their fellow community members would disclose is not nearly as relevant as considering a reasonable person in the patient’s position, and vice versa. For those clients not yet sued, advise them to properly document the process of informed consent. That way, should they get sued, the medical record will speak for itself on this topic.

When a client has become the object of a medical malpractice suit involving an accusation of failure to inform, step back from studying the medical records and determine whether your physician client provided the proper advice and counseling to his or her patient. And thoroughly prepare your clients to testify in depth regarding how they discussed (and documented) the pros and cons of a particular medical procedure with their patients.



Follow Us on  
**TWITTER!**  
<http://twitter.com/stevesalkin>

**ALM REPRINTS**  
TURN YOUR GOOD PRESS INTO GREAT MARKETING!  
Contact us at: 347-227-3382 or visit  
[www.almreprints.com](http://www.almreprints.com)  
Reprints are available in paper and PDF format.

# VERDICTS

## MENTAL HEALTH FACILITY COULD BE RESPONSIBLE FOR LETTING PATIENT LOOSE

A federal judge sitting in New York has ruled that a mental health facility may be sued for releasing a patient on a weekend pass after that patient, who went to visit his mother, killed his mother's neighbor. *Fox v. Marshall*, 14183/08, N.Y.L.J. 8/16/09 (Sup. Ct., Nassau Cty.).

In November 2005, Evan Marshall was voluntarily admitted to a residential treatment program operated by a facility run by SLS Residential Inc. He had no violent criminal history. In August 2006, the SLS facility he was then staying in, in Brewster, NY, issued him a pass to visit his mother in Glen Cove, NY. While there, he broke into the next-door-neighbor's home and dismembered her. Marshall pleaded guilty to killing his mother's 57-year-old neighbor in September 2007.

The murder victim's family sued both the mental health facility and Marshall's mother. SLS sought dismissal, arguing that because Marshall's stay with them was voluntary, the facility lacked the authority to control his conduct or to restrict him from leaving the premises. The court disagreed, finding that because Marshall had signed an agreement that limited his freedom of movement before entering the facility, SLS had the ability to exercise control over his movements. It was also alleged that Marshall kept disturbing pornography in his room and had at least twice used cocaine while in the SLS facility, and that Marshall's proclivities could have been discovered by SLS staff through their routine searches of patient rooms. After he committed his crime, a "to do" list was found in his room that said, "Don't get caught. Move into another rehab program. Kill a girl. Do cocaine off her corpse. Do more cocaine. Do more cocaine. Do more cocaine. Next time I do cocaine, I will kill a girl." The plaintiffs alleged that this list and some sadomasoch-

istic pornography kept by Marshall were removed from his room by SLS staffers after the murder. Those allegations, the court found, must "provoke further inquiry into the activities of [SLS] and militate against premature dismissal of the action against them."

As to Marshall's mother's exposure to liability, the court held that, while parents are normally not liable for their grown children's acts, "a duty may be imposed" upon Ms. Marshall "to the extent that she took custody of or assumed responsibility" for her son.

## ILLINOIS HIGH COURT REJECTS ARGUMENTS FOR TARASOFF-LIKE LIABILITY

The Illinois Supreme Court reversed an appellate court finding that the survivors of a woman killed by her psychiatric patient husband had alleged sufficient facts regarding the defendant's medical care providers' duty to warn the deceased about the violent propensities of her husband to permit the case to go to trial. *Tedrick v. Community Resource Center Inc.*, --- N.E.2d ---, 2009 WL 3063361 (Ill. 9/24/09).

Psychiatric patient Richard Marshall allegedly sought treatment from the defendant physicians, psychologists and social workers because of his paranoid delusions that his wife was committing adultery and that she was trying to poison him. He had had thoughts of killing his wife and had threatened to kill her before he actually committed the murder. The wife's survivors brought suit claiming the defendants "knew or should have known" of Marshall's paranoid delusions and his thoughts and threats of killing his wife; that it was reasonably foreseeable to defendants that he would injure and/or kill his wife; and that they knew or should have known that he posed a specific threat of harm to his wife. The plaintiffs also claimed the defendants took it upon themselves, either gratuitously or

for consideration, to render services to Marshall, which defendants recognized or should have recognized as necessary for the protection of Marshall's wife. Plaintiffs further claimed that Marshall's wife relied upon their undertaking these duties; assumed that they would appropriately evaluate, treat and supervise Marshall; and relied upon them warning her and the authorities if Marshall posed a threat to her. Marshall's wife was not a patient of the defendants.

The defendants moved for dismissal. Plaintiffs and defendants all agreed that *Tarasoff v. Regents of the University of California*, 17 Cal.3d425 (1976), is the "lead case" and the case "most cited" for holding that a mental-health-care provider owes a duty to warn and protect a nonpatient third party when a patient confides his intention to kill an identified third party and later kills the third party. Illinois had not directly addressed the issue of mental health care provider liability in such cases, so both sides offered the cases of other jurisdictions in urging the court's support or rejection of a *Tarasoff*-like rule for the state.

Defendants also argued that under Illinois law, as enunciated in *Kirk v. Michael Reese Hospital & Medical Center*, 117 Ill.2d 507 (1987), a plaintiff cannot generally maintain a medical malpractice action absent a direct physician-patient relationship between the doctor and plaintiff. In *Kirk* (a case that did not involve a specific threat to a known third party), the plaintiff was a passenger in a car driven by a man who had taken psychiatric medication and then consumed alcohol. The plaintiff sought recovery from the prescribing doctor on the basis that the psychiatric patient/driver had not been warned of the side effects of the medication. The *Kirk* plaintiff's argument was unsuccessful before the Illinois Supreme Court, which determined that he could not "maintain a

*continued on page 12*

---

## Verdicts

continued from page 11

medical malpractice action absent a direct physician-patient relationship between the doctor and plaintiff or a special relationship, as present in *Renslow*, between the patient and the plaintiff.” (In *Renslow v. Mennonite Hospital*, 67 Ill. 2d 348 (1977), a 13-year-old patient with Rh-negative blood was given a transfusion of Rh-positive blood by the hospital, thereby sensitizing her blood to the Rh-positive factor. The hospital did not inform the patient of the error or of its effects. As a result of the error, the patient’s daughter was born several years later with permanent damage to her brain, internal organs, and nervous system. The Illi-

nois Supreme Court determined that the defendant’s duty of care to the patient should be transferred to the patient’s infant daughter because of the special relationship between the infant and her mother and because the injury to the infant was the direct result of the negligent treatment her mother received.)

Here, there was no physician/patient relationship between the health care providers and Marshall’s wife. The intermediate appellate court had found, however, that the case should go forward because a “special relationship” akin to that found in *Renslow* existed due to Marshall’s marriage to his victim and the fact that she was an active participant in his medical care, providing the defendants with information regarding

her husband’s changeable moods and behaviors and consulting with the defendants regarding her concerns about whether her husband would act on his ideas and threats and do her harm. The Supreme Court disagreed, noting that the relationship between a fetus and its mother, as in *Renslow*, is far more intimate a relationship than that between a husband and wife. It declined to stretch the concept of a “special relationship” to include the marriage relationship, thus also declining to find that, in Illinois, mental health care providers have a duty to warn third-party non-patients when their patients make specific threats to harm them.

—❖—

---

## Mandatory Inoculation

continued from page 6

it should not invade the domain of local authority except when it is plainly necessary to do so in order to enforce that law. The safety and the health of the people of Massachusetts are, in the first instance, for that commonwealth to guard and protect. They are matters that do not ordinarily concern the national government. So far as they can be reached by any government, they depend, primarily, upon such action as the state, in its wisdom, may take; and we do not perceive that this legislation has invaded any right secured by the Federal Constitution.

Although the Massachusetts law in question did not exempt from its requirements those who were deemed medically unfit to receive the smallpox inoculation, the Court refused to invalidate the law on that basis, because the *Jacobsen* defendant had shown no such disability. However, the Court reserved the right to invalidate the rule, or similar rules, if a case came before it involving a person who could show an inoculation would likely do him harm.

---

## CONCLUSION

The flu inoculation requirements imposed by New York law and by individual hospitals and medical centers do exempt from their requirements those who, for medical reasons, should not receive them.

***The laws and job requirements like those we have discussed run counter to many Americans’ idea of personal liberty rights.***

The debate does not stop there, however. Laws and job requirements like those we have discussed run counter to many Americans’ idea of personal liberty rights. Although most of us have become accustomed to our schools’ requirements that children receive their childhood immunizations before they can attend school, there is one glaring difference between these regulations and some of the new laws and rules pertaining to flu vaccines for health care providers. Schools generally permit

un-immunized students to attend if they (or, more likely, their parents) have religious or moral objections to inoculations. Not so many of the newer rules, which could interfere with some people’s ability to continue in their chosen profession. The New York State Nurses Association made this point in an open letter issued in response to the state health commissioner’s open letter. In it, they said: “The [New York] regulation’s impact on the state’s shortage of nurses could be significant. There is no exemption for individuals with religious or cultural preferences regarding immunization. This rule effectively blocks these individuals from earning their livelihood as nurses. It’s possible that nurses will leave the profession or choose another career because of this mandate; a serious threat at a time when the shortage of nurses in New York State is expected to reach 20,000 within a decade.”

—❖—

The publisher of this newsletter is not engaged in rendering legal, accounting, financial, investment advisory or other professional services, and this publication is not meant to constitute legal, accounting, financial, investment advisory or other professional advice. If legal, financial, investment advisory or other professional assistance is required, the services of a competent professional person should be sought.

---

To order this newsletter, call:  
1-877-256-2472

On the Web at:  
[www.ljnonline.com](http://www.ljnonline.com)