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Medicare Statute May Extend Appeals Rights to Assignee Physicians But Not Non-Assignee Physicians

The United States Court of Appeals for the Second Circuit held that a medicine statute extending appeals rights to assignee physicians, but not to non-assignee physicians is permissible.¹

At various times in 1992 and 1993, plaintiffs Robert Sloan and Kenneth Y. Sunew performed concurrent invasive monitoring on patients undergoing surgery at various New York hospitals.² Sloan accepted assignment for some, but not all, services.³ Sunew did not accept assignment for his services.⁴

Sloan and Sunew had exercised their option to refuse assignment of their patients' Medicare claims for concurrent invasive monitoring procedures performed on or after January 1, 1991.⁵ Plaintiff alleged the carriers' determinations of the Medicare-approved charge directly impacted their ability to bill patients by limiting charges for their services.⁶ They further asserted because they had no right under the regulations to appeal, they had no recourse to rectify the alleged improper fixing of the charge.⁷ Specifically, Sloan and Sunew asserted the Department of Health and Human Services violated the Administrative Procedure Act (APA), and the Fifth Amendment Equal Protection and Due Process rights.⁸

The court found the Secretary's decision to extend appeals rights only to assignee physicians as a permissible interpretation of the Medicare statute.⁹ By granting appeals rights to assignee-physicians, the regulation encourages physicians to accept assignments, thereby decreasing additional charges to patients.¹⁰ The court affirmed the findings of the appellate court, dismissing appellants' claim that the non-extension of

²See id. at *12.
³See id.
⁴See id.
⁵See id. at *13.
⁷See id. at *14.
⁸See id.
⁹See id. at *22.
¹⁰See id. at * 20.

**CONSTITUTIONAL LAW**

**Employment Anti-Discrimination Provision of the ADA Held an Invalid Exercise of Congress’s Enforcement Power**

The United States District Court for the Northern District of New York dismissed the plaintiff’s complaint of employment discrimination under both the Americans with Disabilities Act (ADA) and the state Human Rights Law (HRL).12 The court found a lack of subject matter jurisdiction to decide whether plaintiff suffered a disability under the ADA because of immunity to suit which state Department of Transportation had under the Eleventh Amendment of the United States Constitution.13

The court dismissed the complaint on the basis of whether the state had waived its Eleventh Amendment immunity from suits in federal court or if Congress had abrogated immunity through statutory law.14 Because the court found neither situation applied to the plaintiff’s suit, the plaintiff’s claim of alleged discrimination under HRL was dismissed.15 The court also found that there was no state waiver of immunity under the ADA claim.16 The court concluded that while Congress was clear in its intent to abrogate the state’s immunity, the ADA’s provision for non-discriminatory employment was not a valid exercise of Congress’s power.17

The provision was invalid because the imposition of a duty to accommodate any disability up to a point of undue hardship was too broad.18 The provision did not take into account any evidence that refusal to accommodate was irrational or driven by deliberate discrimination.19

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13 See *id.* at 136.
14 See *id.* at 137.
15 See *id.*
16 See *id.* at 152.
17 See *Kilcullen*, 33 F. Supp. 2d at 152.
18 See *id.*
19 See *id.*
Furthermore, the costs of a reasonable accommodation for a state employer would likely be higher than for a private employer. Because non-discriminatory employment was an invalid exercise of Congress’s power, and Eleventh Amendment immunity applied to the defendant, the court found a lack of subject matter jurisdiction to hear the plaintiff’s claims. Kilcullen v. New York State Dep’t of Transp., 33 F. Supp. 2d 133 (N.Y. 1999).

**CONTRACT**

Government Obligated to Make Annuity Payments Under the Military Claims Act When an Insurance Company Went Into Conservatorship and Payments Were Reduced

The United States Court of Appeals, Federal Circuit, reversed a Court of Federal Claims’ decision which granted summary judgment in favor of the United States government in a case involving an agreement to pay a claim under the Military Claims Act (MCA). The court held that the government was required by federal law to make payments, which were agreed to in the settlement regardless of the fact that the annuity became deficient through a conservatorship of the insurance company.

The United States entered into a settlement agreement after the plaintiff suffered injuries at birth while at a naval hospital. The agreement included a purchase of an annuity by the government on the defendant’s behalf. Subsequent to the settlement agreement, the insurance company, through which the annuity was purchased, went into conservatorship and instituted a rehabilitation plan which the plaintiff’s opted to participate in but which significantly reduced the amount of the original agreed upon payments. The plaintiff argued that the government

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20 See id. at 149.
21 See id. at 152.
23 See id. at 1188.
24 See id. at 1186.
25 See id.
26 See id. at 1185, 1186.
was now in breach of the original settlement agreement by virtue of the fact that the annuity payments no longer corresponded to those originally agreed to.\textsuperscript{27} Alternatively, the government argued that the agreement did not include a guarantee on the annuity payments and, as such, prevailed on these grounds.\textsuperscript{28}

The two issues the court considered were whether the lower court had jurisdiction over the claim, and whether the government had breached the contract instituted at the settlement.\textsuperscript{29} The court determined that the Court of Federal Claims had jurisdiction by virtue of the Tucker Act, in cases where there is a valid contract made with the United States, and that Congress had not expressly stated that another entity shall have jurisdiction.\textsuperscript{30} Although the government argued that jurisdiction was displaced by the MCA, which covers military claims payments under the direction of the Secretary of Defense, the court noted the MCA did not pertain to the breach of agreements to compensate for plaintiff’s claims.\textsuperscript{31} Since the agreement at issue was less like a procurement agreement and more like an express contract in which each party relinquished the right to litigate in return for settlement benefits, the court held MCA did not displace jurisdiction in this instance.\textsuperscript{32}

In determining whether the contract had been breached by the government, the court considered whether the plain language of the agreement gave rise to an interpretation that the annuity payments were compulsory, as the plaintiffs argued, or whether, as the government argued, only the type of annuity purchased was guaranteed.\textsuperscript{33} The court concluded that the plaintiff’s interpretation was more accurate and that the government was not released from the obligation to pay as agreed simply by relegating the duty of paying to the life insurance company.\textsuperscript{34} Furthermore, the court held that a provision in the contract which required a highly rated insurance company did not imply that the government relinquished control over the payments upon purchase.\textsuperscript{35} Additionally,
since the government drafted the contract the court read this ambiguity in favor of the plaintiff.\textsuperscript{36} \textit{Massie v. United States}, 166 F.3d 1184 (Fed. Cir. 1999).

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**Hospital Bylaws Do Not Constitute Contract for Continuing Right to Staff Privileges**

The Supreme Court of Iowa held hospital bylaws did not constitute a contract with plaintiffs for continuing right to staff privileges.\textsuperscript{37}

In January 1995, the Genesis Medical Center entered into a contract with Anesthesia and Analgesia, P.C. (A & A) under which services had previously been provided by fifteen other anesthesiologists, including plaintiffs who had been on staff at Genesis since 1994.\textsuperscript{38}

Under the medical center’s new contract, A & A was to be the exclusive provider of anesthesiology services, subject to a provision in the contract allowing independent anesthesiologists, including plaintiffs, to provide services under agreement with Genesis within a limited time period.\textsuperscript{39} Any extensions of the deadline were subject to A & A’s consent.\textsuperscript{40} Furthermore, the Genesis-A & A agreement provided that A & A would not unreasonably withhold its consent to an extension of the deadline.\textsuperscript{41}

Plaintiffs, who initially refused Genesis’s offer, later attempted to enter into a contract with Genesis after the deadline.\textsuperscript{42} While A & A consented to two extensions of the deadline, they refused to consent to a third.\textsuperscript{43} Plaintiffs sued Genesis, A & A, and the medical director of anesthesiology services at the hospital on several theories, including breach of medical staff bylaws.\textsuperscript{44} Plaintiffs argued Genesis, by entering into an exclusive agreement with A & A and a separate medical director’s contract, revoked or curtailed plaintiffs’ medical staff membership rights...
and clinical privileges to provide patient care. They sought damages based on breach of contract of the medical staff bylaws.

The court found the hospital bylaws did not constitute a contract so far as any continuing right to staff privileges, and held in order for these bylaws to be considered an agreement for continued employment, the plaintiffs must establish "with sufficient definiteness" that an offer of continued employment was a part of the agreement. No such agreement was expressed in the bylaws. Accordingly, the judgment of the trial court was affirmed. Tredea & Wells v. Anesthesia & Analgesia, P.C. & Genesis Med. Ctr., No. 163/96-1117, 1998 Iowa Sup. LEXIS 205 (Iowa Sept.23, 1998).

DISABILITY

Private Insurance Must Apply to an Employee Who Claims Total Disability Because Sickness First Began When Employee was Able to Work

The United States Court of Appeals for the Second Circuit remanded a summary judgment claim in favor of defendant insurance company because plaintiff employee was entitled to total disability benefits. Plaintiff was entitled to benefits because he was employed as a surgeon when the insurance policy was initiated.

Early in his career as a surgeon, plaintiff purchased an insurance policy to protect him from any impending disability. Fourteen years later premature atrial contractions prohibited him from continuing surgery. He then became a medical director for an HMO. His

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45 See id. at *20.
47 See id. at *31.
48 See id.
49 See id.
51 See id.
52 See id. at 182.
53 See id.
condition worsened, permanently prevented him from returning to work. The policy clarified in order for benefits to be received, sickness must be revealed while the policy is in force. Furthermore, total disability is defined as preventing an employee from performing normal tasks.

After plaintiff applied for total disability, the insurance company denied benefits. Defendant claimed the policy implied that the insured must have been performing his regular occupation. Defendant argued that plaintiff's most recent occupation was not surgery when the claim was filed, therefore, benefits were denied.

The court found state insurance law mandates when there is an ambiguity in an insurance policy, it must be construed to favor the insured. Furthermore, because the policy expressly stated that in order to recover benefits, the sickness must appear when policy is in force the court refused to grant summary judgment and remanded the case. 


Falsity in Employer's Explanation for Termination in FMLA Claim Requires Further Proceedings

The United States Court of Appeals for the Seventh Circuit reversed a lower court's decision which granted the defendant employer's motion for summary judgment in a suit by plaintiff employee, who claimed that termination by the employer was discrimination under the American with Disabilities Act (ADA) and also in retaliation for exercising rights under the Family and Medical Leave Act (FMLA). The court found that there was a genuine issue of material fact regarding the employer's explanation for the employer's termination.

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54 See id.
55 See Goldberger, 165 F.3d at 182.
56 See id. at 181.
57 See id.
58 See id.
59 See id. at 182.
60 See King v. Preferred Tech. Group, 166 F.3d 887, 889 (7th Cir. 1999).
61 See id. at 894.
The employee, after being diagnosed with an illness, took a leave of absence under FMLA. The employee was also granted numerous leave extensions by the employer. However, after a release by the employee’s physician release to return to work, the employer terminated the employee upon a failure to return to work. The plaintiff submitted affidavits and depositions explaining his failure to return to work was due to the employer’s instructions not to return due to missing physician documentation in the employee’s file. While the employer’s human resources manager informed the employee of being unable to return to work until the missing physician slips were replaced, the employer never gave any further information regarding the number of missing slips or the dates of the missing slips.

Under FMLA, the employee must establish that the employer engaged in intentional discrimination, similar to any other retaliatory discharge case. If the employee does not have any direct evidence of discrimination, the employee must show employment in a protected activity, the employer terminated that employment, and a causal connection between the protected activity and the termination existed. Since the employee met this initial step, the employer had the burden to show a legitimate reason for terminating the employee. The employer succeeded by demonstrating that at the time of the termination, all the employees were part of a collective bargaining agreement that allowed automatic termination if the employee did not return to work at the expiration of the leave of absence. The employee was fired due to this policy. Since the employer gave a legitimate, non-discriminatory reason for terminating the employee, the burden returned to the employee to show falsity in the employers reasoning for the dismissal. The court found that there was evidence supported by affidavits and depositions to show that the defendant’s explanation for the employee’s termination was

64 See id. at 890.
65 See id.
66 See id.
67 See King, 166 F.3d at 894.
68 See id.
69 See id. at 892.
70 See id.
71 See id.
72 See King, 166 F.3d at 893.
73 See id.
74 See id. at 893-94.
false.\textsuperscript{75} Thus, the court held that the lower court’s summary judgment order was inappropriate and the court remanded the case for further proceedings.\textsuperscript{76} \textit{King v. Preferred Technical Group, 166 F.3d 887 (7th Cir. 1999)}.

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### Preclusion of an ADA Claim Not Automatic Upon the Receipt of Disability Benefits Where Unpaid Medical Leave Amounts to a Reasonable Accommodation

The United States Court of Appeals of the Ninth Circuit reversed and remanded a lower court’s decision granting summary judgment to an employer when an employee, who suffered from syncopal episodes, alleged violations of the Americans with Disabilities Act (ADA).\textsuperscript{77} The court held an issue of fact existed as to whether the plaintiff was a qualified person with a disability and whether the plaintiff posed a “direct threat” to others because of her disability.\textsuperscript{78}

The plaintiff was a sales associate for Wal-Mart who received benefits including short-term medical leaves of absence for up to one year.\textsuperscript{79} After suffering three syncopal episodes, the plaintiff, with the advice of her employer, went on extended medical leave and applied for state temporary disability benefits (SDI).\textsuperscript{80} She was subsequently treated by several physicians and hospitalized for the disorder.\textsuperscript{81} During one hospitalization, the employer attempted to contact her at home without success and subsequently terminated her employment.\textsuperscript{82} This termination occurred without notification by certified letter and accompanying three-day response period as per company policy.\textsuperscript{83}

The court determined the lower court erred in finding the plaintiff was not a qualified person with a disability.\textsuperscript{84} The lower court determined the plaintiff was not a qualified person since her application statements for

\textsuperscript{75}See id. at 894.
\textsuperscript{76}See id.
\textsuperscript{77}See Nunes v. Wal-Mart Stores, Inc., 164 F.3d 1243, 1245 (9th Cir. 1999).
\textsuperscript{78}See id. at 1245-48.
\textsuperscript{79}See id.
\textsuperscript{80}See id.
\textsuperscript{81}See id.
\textsuperscript{82}See id., 164 F.3d at 1246.
\textsuperscript{83}See id. at 1245-46.
\textsuperscript{84}See id.
SDI benefits precluded a recovery on her ADA claim, and because her doctors had also certified on her SDI application an inability to do the essential functions of her job on the date as of her termination date. The court determined application for disability benefits does not automatically bar a plaintiff from establishing that she is a qualified person with a disability under the ADA and that the lower court misapplied the "qualified person" standard. Furthermore, the court determined it was inaccurate for the lower court to find that the plaintiff was totally disabled at the point of her termination.

A "qualified person" under the ADA is one who is able to perform the essential functions of her job "with or without reasonable accommodation." The court found the lower court erred in failing to acknowledge that unpaid medical leave could be considered a reasonable accommodation under the ADA if it does not impose an undue hardship upon the employer. However, this determination required a fact-specific, individualized inquiry. Because of the need for this determination coupled with the fact that the plaintiff was a good employee who went on medical leave at the advice of her employer, the court found there existed issues of material fact as to whether the leave of absence constituted a reasonable accommodation.

The court similarly determined the existence of material issues of fact as to whether the plaintiff posed a "direct threat to the health and safety of other individuals in the workplace." In determining whether a direct threat exists, the court is required to consider first whether the employer has demonstrated that the employee cannot perform the job without a significant risk of harm. Secondly, the court must evaluate whether the employer can make a reasonable accommodation so the employee can perform the job without this risk. The Ninth Circuit determined the lower court failed in this analysis by virtue of the fact that a significant risk was found based only on doctors' testimony taken two years after the

85See id. at 1245
86See id. at 1246.
87See Nunes, 164 F.3d at 1247.
88See id. at 1246.
89See id.
90See id.
91See id. at 1246, 1247.
92See Nunes, 164 F.3d at 1247.
93See id. at 1247-48.
94See id. at 1248.
termination date and therefore not in evidence at the time she was terminated. Furthermore, this testimony failed to establish that the plaintiff posed a significant risk to others. \textit{Nunes v. Wal-Mart Stores, Inc.,} 164 F.3d 1243 (9th Cir 1999).

\section*{FOOD DRUG ADMINISTRATION}

\textbf{Nicotine Addiction Fails for Medical Monitoring Claim}

The United States Court of Appeals for the Third Circuit held smokers failed to meet the requirements of Fed. R. Civ. P. 23(b)(2) to be certified as a class for the claim of medical monitoring. Plaintiffs were Pennsylvania residents who began smoking cigarettes before the age of 15 and who had smoked for many years. Plaintiffs filed an amended complaint against the major American tobacco companies alleging the claim for medical monitoring. Plaintiffs sought certification under Fed. R. Civ. P. 23(b)(2) for “[a]ll current residents of Pennsylvania who are cigarette smokers as of December 1, 1996 [the day the amended complaint was filed in federal court] and who began smoking before age 19, while they were residents of Pennsylvania.” In Pennsylvania, a plaintiff, to state a claim for medical monitoring, must establish the following:

\begin{enumerate}
\item exposure to greater than normal background levels;
\item to a proven hazardous substance;
\item caused by the defendant’s negligence;
\item as a proximate result of the exposure, plaintiff has a significantly increased risk of contracting a serious latent disease;
\item a monitoring procedure exists that makes the early detection of the disease possible;
\end{enumerate}

\textsuperscript{95}See id. at 1248. 
\textsuperscript{96}See id. 
\textsuperscript{97}See Barnes v. The American Tobacco Co., 161 F.3d 127, 130 (3d Cir. 1998). 
\textsuperscript{98}See id. at 130. 
\textsuperscript{99}See id. at 131. 
\textsuperscript{100}Id. at 131, 132.
(6) the prescribed monitoring regimen is different from that normally recommended in the absence of the exposure; and

(7) the prescribe monitoring regime is reasonably necessary according to contemporary scientific principles.\(^{101}\)

The court announced to be certified, a class must first satisfy the four elements of Fed. R. Civ. P. 23(a):

(1) numerosity;
(2) commonality;
(3) typicality; and
(4) adequacy of representation.\(^{102}\)

The court explained, after the first four elements are established, a class will only be certified under Fed. R. Civ. P. 23(b)(2) if the final relief sought satisfies the class as a whole.\(^{103}\) The court held while plaintiffs met the conditions of Fed. R. Civ. P. 23(a) for class certification, the class could not be maintained under Fed. R. Civ. P. 23(b)(2) because nicotine addiction must be determined on an individual basis.\(^{104}\) Thus, the relief sought per potential class participant would not satisfy the class as a whole.\(^{105}\) Accordingly, the court denied plaintiffs' class certification for the claim of medical monitoring.\(^{106}\) *Barnes v. American Tobacco Co.*, 161 F.3d 127 (3rd Cir. 1998).

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**FDA Regulation Requiring Pre-approval of Health Claims for Dietary Supplement Labels is Vague and Violated the First Amendment**

The United States Court of Appeals for the District of Columbia reversed a lower court decision dismissing plaintiffs' suit challenging a Food and Drug Administration (FDA) rule requiring FDA pre-approval of certain

\(^{101}\)See id. at 138.

\(^{102}\)See Barnes, 161 F.3d at 140.

\(^{103}\)See id. at 141.

\(^{104}\)See id. at 146.

\(^{105}\)See id.

\(^{106}\)See id.
dietary supplement claims by the manufacturer.\textsuperscript{107} This FDA pre-approval was required before the manufacturers could place health claims for certain diseases on the product label.\textsuperscript{103}

The plaintiffs, as dietary supplement manufacturers, failed to persuade the FDA of four health claims.\textsuperscript{109} The FDA refusal to approve the health claims was based on the lack of a "significant scientific agreement" standard for the validity of dietary supplement health claims.\textsuperscript{110} The FDA, while stating the evidence was inconclusive, never defined how "significant" was to be measured.\textsuperscript{111} Furthermore, when the plaintiffs suggested the use of FDA disclaimers to supplement the health claims, the FDA refused.\textsuperscript{112} The plaintiffs claimed that their First Amendment rights had been violated, since under the Administrative Procedure Act, the FDA needed to state how the "significant scientific agreement" standard was measured.\textsuperscript{113}

The court held the manufacturers' First Amendment rights were violated when the FDA declined to use disclaimers in this case.\textsuperscript{114} The court found such a violation as a restriction of commercial free speech, determining while a government interest exists in ensuring the accuracy of marketplace advertisements, the FDA rule did not meet this interest.\textsuperscript{115} The court held disclaimers would be constitutionally preferable to complete suppression of the health claims, especially when there was no evidence that the plaintiff's supplements threatened consumer safety.\textsuperscript{116} A prominent disclaimer could indicate the inconclusiveness of the evidence relating to the particular dietary supplement.\textsuperscript{117}

The court also found that the "significant scientific agreement" standard was vague and unarticulated, and reversed the district court's decision with instructions for the FDA to reconsider the rule.\textsuperscript{118} The court held on the remand the agency must be specific and adequately explain

\textsuperscript{107}See Pearson v. Shalala, 164 F.3d 650, 651 (D.C. Cir. 1999).
\textsuperscript{108}See id. at 652.
\textsuperscript{109}See id. at 653.
\textsuperscript{110}Id.
\textsuperscript{111}See id.
\textsuperscript{112}See Pearson, 164 F.3d at 654.
\textsuperscript{113}See id.
\textsuperscript{114}See id. at 658.
\textsuperscript{115}See id. at 657.
\textsuperscript{116}See id. at 656.
\textsuperscript{117}See Pearson, 164 F.3d at 659.
\textsuperscript{118}See id. at 660.
any rejected labeling claim. Such FDA action would then be sufficient
guidance towards defining the "significant scientific agreement"
standard. \(^{120}\) *Pearson v. Shalala*, 164 F.3d 650 (D.C. Cir. 1999).

HEALTH MAINTENANCE ORGANIZATIONS

Certification Denied for Class of Plaintiffs Alleging Fraud
and Unjust Enrichment because No Reliance for each
Class Member can be Shown

The Court of Appeals of Florida reversed a trial court decision certifying
a class of plaintiffs who field suit against the defendant HMO.\(^ {121}\) The
court would not certify the class under the state law because class actions
seeking relief from separate contracts on the basis of fraud were
prohibited.\(^ {122}\)

The plaintiffs claimed that the defendant either misrepresented and
or failed to disclose terms of its arrangements with its physicians and
primary care physicians to potential enrollees, alleging claims for fraud
and unjust enrichment.\(^ {123}\) Specifically, the plaintiffs claimed that Humana
failed to disclose that

1. the physicians were paid a flat rate per month,
2. Humana's financial arrangements with the physicians created
an incentive to not treat,
3. permission was required from Humana before a physician
could admit a member into the hospital,
4. that Humana's contracts with the physicians contained "gag
clauses," and
5. members had to use Humana providers for treatment.\(^ {124}\)

\(^{119}\) See id.
\(^{120}\) See id. at 661.
\(^{121}\) See Humana Inc. v. Castillo, 728 So. 2d 261, 264 (2d Dist. 1999).
\(^{122}\) See id. at 264.
\(^{123}\) See id.
\(^{124}\) See id. at 261.
The plaintiffs attempted to represent a class of those persons who had enrolled in the particular Humana plan between 1987 and 1997 by filing a motion to certify the class.\textsuperscript{125}

The trial court certified the class of plaintiffs by focusing only on the defendant's course of conduct and at whether the defendant had failed to disclose material facts during the sale of its HMO.\textsuperscript{126} However, the Court of Appeals applied state law in determining that a party asserting fraud must also show that he or she would not have entered into the contract if all the information had been disclosed.\textsuperscript{127}

The court held in order to certify a class, the trial court must first determine whether the alleged class representatives can prove their own individual cases.\textsuperscript{128} If the representatives cannot prove their own case, including reliance in a fraud case, the class cannot be certified.\textsuperscript{129} The court also found that under state law, class actions alleging fraud in separate contracts are prohibited.\textsuperscript{130} This is due to the fact while one member of the class may have evidence of what was relied upon to form a contract, such evidence may be lacking for another member of the class.\textsuperscript{131} Because the plaintiff representatives could not prove reliance for each class member in their fraud case against the defendant, the court therefore held the class could not be certified.\textsuperscript{132} \textit{Humana Inc. v. Castillo}, 728 So. 2d 261 (2nd Dist. 1999).

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**INFORMED CONSENT**

**Physician's Lack of Informed Consent May Constitute Battery**

The Court of Appeals of Indiana held that a physician may be liable for lack of informed consent, fraud, punitive damages for negligence, and

\textsuperscript{125}See id.
\textsuperscript{126}See Humana, So. 2d at 263.
\textsuperscript{127}See id., at 264.
\textsuperscript{128}See id. at 265.
\textsuperscript{129}See id.
\textsuperscript{130}See id. at 264.
\textsuperscript{131}See Humana, 728 So. 2d at 265.
\textsuperscript{132}See id. at 265.
battery.\textsuperscript{133} The court reinforced the refusal of summary judgment on all issues, since no genuine issue of material fact was found.\textsuperscript{134}

Defendant performed back surgery on plaintiff, his patient. Plaintiff claimed defendant inaccurately explained the risks of the surgery, misrepresented the risks, used inappropriate behavior eliciting punitive damages, and fraudulently induced plaintiff to endure surgery, constituting battery.\textsuperscript{135}

To provide informed consent, a physician must obtain written proof from his patient that the procedure, patient’s condition, risks of the procedure, and any potential alternatives prior to the procedure were clearly explained.\textsuperscript{136} Defendant told plaintiff that paralysis may randomly occur if surgery was not performed.\textsuperscript{137} Because there was a question as to whether or not the defendant provided an alternative to the plaintiff, there was a genuine issue of material fact.\textsuperscript{138} Thus, summary judgment was denied.\textsuperscript{139}

If a statement is fraudulent, it must be untrue and known to be untrue, and known that another is relying on that fact.\textsuperscript{140} While defendant claimed that his statements were true, experts disagreed as to the truth of the statement.\textsuperscript{141} Also, another court held that any physician who violates a patient’s informed consent commits battery.\textsuperscript{142} Therefore the summary judgment ruling must be reversed.\textsuperscript{143} \textit{Cacdac v. West, 705 N.E.2d 506 (Ind. Ct. App. 1999)}.

\begin{itemize}
\item \textsuperscript{133}See \textit{Cacdac v. West, 705 N.E.2d 506, 507 (Ind. Ct. App. 1999)}.
\item \textsuperscript{134}See \textit{id. at 506}.
\item \textsuperscript{135}See \textit{id. at 507}.
\item \textsuperscript{136}See \textit{id. at 508-09}.
\item \textsuperscript{137}See \textit{id. at 509}.
\item \textsuperscript{138}See \textit{Cacdac, 705 N.E.2d at 510}.
\item \textsuperscript{139}See \textit{id. at 509}.
\item \textsuperscript{140}See \textit{id. at 509}.
\item \textsuperscript{141}See \textit{id. at 510}.
\item \textsuperscript{142}See \textit{id. at 511}.
\item \textsuperscript{143}See \textit{Cacdac, 705 N.E.2d at 512}.
\end{itemize}
State Obligated to Operate Medicaid Policy Through a Single Agency and May Not Delegate Functions

The Court of Appeal, Second District, in California modified a lower court holding that it was not illegal for the state Medicaid agency to delegate certain functions including auditing and overpayment to the Controller. The issues addressed in this appeal involved whether the laboratory had standing to bring a claim against the Controller and whether the Controller was authorized under federal law to undertake functions of the state Medicaid agency. The court ruled federal and state Medicaid laws required a “single agency” to carry out agency policy and through delegation of certain powers to the state Controller, the state Medicaid agency was not properly complying with these laws.

Plaintiff, a diagnostic laboratory, provided physicians with testing services and received a significant amount of its profits from Medicaid patients. When the state Controller withheld a portion of these payments, the laboratory filed a complaint alleging it was illegal for the state Medicaid agency to delegate certain functions to another entity.

The court found the laboratory had standing, and rejected the defendant’s argument, that a “single agency” policy affected the plaintiff by only indirectly precluding the plaintiff from taking action. Since the case involved a writ of mandate, standing was appropriate since it was a less restrictive standard applied to private interest.

According to federal law, the court found while the state may utilize the services of other agencies in implementing policy, the state may not delegate duties to other agencies. According to federal law, Medicaid

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142 See id. at 832, 833.
143 See id. at 832.
144 See id. at 831.
145 See id. at 830-31.
146 See Doctor’s Med. Laboratory, 81 Cal. Rptr. 2d at 833.
147 See id. at 831.
148 See id.
agencies are to be strictly "single agencies."\textsuperscript{152} Thus, by delegating auditing and remedial functions to the Controller, the state Medicaid agency, in effect, was operating through two separate agencies.\textsuperscript{153}

Secondly the court determined that by delegating these functions to the Controller, the state Medicaid agency was out of compliance with its own procedure for review.\textsuperscript{154} According to federal law the agency was required to have in place a review process to address any disputes prior to attempting to get back any overpayments.\textsuperscript{155}

The court further noted the state Medicaid agency represented to the federal government the existence of its own agency branch that was responsible for the identification of any excess payments and for implementing corrective action.\textsuperscript{156} The Controller's proper function, then, was to issue checks in a non-discretionary manner.\textsuperscript{157} Therefore, the agreement between the state Medicaid agency and the Controller expanding the function of the Controller to include responsibilities of Investigations Division was illegal.\textsuperscript{158} \textit{Doctor's Med. Laboratory, Inc., v. Connell} 81 Cal. Rptr. 2d 829 (Cal. Ct. App. 1999).

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\textbf{Denial of Mental Health Benefits May Be Unreasonable, But Not an ERISA Violation}

The United States Court of Appeals for the First Circuit held that an insurance company acted unreasonably when it denied mental health benefits, but did not violate ERISA by neglecting to provide plaintiff with mental health guidelines.\textsuperscript{159} Because there was no ERISA violation, the insurer cannot be penalized.\textsuperscript{160}

Plaintiff was founder, chairperson, and Chief Technical Officer of her firm.\textsuperscript{161} She suffered a relapse of her mental illness, which was comprised

\textsuperscript{152}See id. at 831 (citing 42 U.S.C. § 1396a(a)(5) (1999)).
\textsuperscript{153}See id. at 832.
\textsuperscript{154}See \textit{Doctor's Med. Laboratory}, 81 Cal. Rptr. 2d at 833.
\textsuperscript{155}See id. at 832-33.
\textsuperscript{156}See id. at 831-32.
\textsuperscript{157}See id. at 831.
\textsuperscript{158}See id. at 832.
\textsuperscript{159}See Doe v. Travelers Ins. Co., 167 F.3d 53, 57, 59 (1st. Cir. 1999).
\textsuperscript{160}See id. at 60.
\textsuperscript{161}See id. at 55.
of an increased sense of disquiet, depression, self-destructive behavior, and suicidal tendencies.\textsuperscript{162}

At the advice of plaintiff's psychiatrist, she investigated the company's insurance policy regarding mental illness.\textsuperscript{163} She discovered the insurance company would cover inpatient hospital care for mental health needs when justified for no more than sixty days.\textsuperscript{164} However, a twenty percent co-pay applied to the patient.\textsuperscript{165}

Plaintiff's psychiatrist requested the insurance company's approval of plaintiff's hospital admission.\textsuperscript{166} The insurance company would not approve because it did not believe the patient's slight suicidal tendencies necessitated inpatient care.\textsuperscript{167} The insurance company believed that outpatient care would suffice.\textsuperscript{168} Nevertheless, the patient checked into the hospital.\textsuperscript{169}

Plaintiff filed suit in a district court for breach of contract and deceptive acts and practices.\textsuperscript{170} Plaintiff won her case because the court believed her claim had been plagued with many procedural errors.\textsuperscript{171} This decision stated that plaintiff should have been reimbursed for her unpaid medical costs, and that defendant had violated ERISA by neglecting to provide plaintiff with the appropriate mental health guidelines.\textsuperscript{172} Defendant appealed.\textsuperscript{173}

Under this particular policy the insurance company not only has the privilege to cover what is medically necessary, but also has the privilege to decide what is medically necessary.\textsuperscript{174} The insurance company also has the power to determine what is medically necessary.\textsuperscript{175} The court held that a reasonableness standard must be applied to this dilemma and the

\textsuperscript{162}See id.
\textsuperscript{163}See id.
\textsuperscript{164}See Doe, 167 F.3d at 55.
\textsuperscript{165}See id.
\textsuperscript{166}See id.
\textsuperscript{167}See id.
\textsuperscript{168}See id.
\textsuperscript{169}See Doe, 167 F.3d at 56.
\textsuperscript{170}See id.
\textsuperscript{171}See id.
\textsuperscript{172}See id.
\textsuperscript{173}See id. at 56.
\textsuperscript{174}See Doe, 167 F.3d at 56.
\textsuperscript{175}See id. at 57.
insurance company unreasonably denied the patient's claim, seeing that the patient had exhibited some suicidal tendencies.\textsuperscript{176}

However, the court did not agree that defendant violated ERISA.\textsuperscript{177} ERISA mandates that guidelines be sent out within thirty days of request.\textsuperscript{178} Plaintiff requested the guidelines but did not receive it within thirty days; instead they arrived approximately forty-five days later.\textsuperscript{179} The court fined defendant for the tardiness, but did not consider defendant's actions as a violation of ERISA.\textsuperscript{180}

Finally, the court awarded attorney's fees and costs to plaintiff.\textsuperscript{181} This case was remanded to determine the amount of the fine.\textsuperscript{182} Doe \textit{v. Travelers Ins. Co.}, 167 F.3d 53 (1st Cir. 1999).

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**RICO Claims Against Insurance Companies May Not Be Precluded By the McCarran-Ferguson Act if the Federal Act Does Not Frustrate State Law**

The Supreme Court of the United States affirmed a Ninth Circuit Court's holding that the McCarran-Ferguson Act, which allows states to regulate the business of insurance, does not bar a policy holder's claim against a defendant insurance company under Racketeer Influence and Corrupt Organizations Act (RICO).\textsuperscript{183} In affirming the decision, the Court analyzed the extent that RICO was compatible with state regulations governing the business of insurance.\textsuperscript{184}

Plaintiffs, as policy holders of Humana's group health insurance, agreed to pay twenty percent of their hospital charges, while Humana was contractually responsible for the balance.\textsuperscript{185} The plaintiffs claim was that both the hospital and Humana secretly agreed to give the defendant insurance company larger discounts, which resulted in the policy holders paying significantly more than the designated portion of their hospital charges.

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\textsuperscript{176}See id. at 58.
\textsuperscript{177}See id. at 59.
\textsuperscript{178}See id.
\textsuperscript{179}See Doe, 167 F.3d at 59.
\textsuperscript{180}See id. at 59.
\textsuperscript{181}See id. at 60.
\textsuperscript{182}See id.
\textsuperscript{184}See id. at 714.
\textsuperscript{185}See id. at 712.
such action, the plaintiffs alleged, was a violation of RICO. The district court granted Humana’s motion for summary judgment, holding that if RICO applied to the case at hand, the court would be permitting Congress to intrude into an area that the McCarran-Ferguson Act expressly left to the states. The McCarran-Ferguson Act allows the states to regulate the business of insurance.

The Supreme Court agreed with the Ninth Circuit holding that the plaintiff’s suit under RICO would not impair, invalidate, or supercede Nevada State law and thus, a RICO claim was valid. This “direct conflict test was laid out in the McCarran-Ferguson Act.” RICO’s private right of action and treble damages provision were similar to the state’s statutory and common law claims for relief for insurance fraud. Furthermore, RICO and the state laws governing the insurance business do not directly conflict. Therefore, the Court held that RICO, by not directly conflicting or frustrating state regulations was not precluded by the McCarran-Ferguson Act.


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If There is a Delay in an Objection to a Trial Court’s Determination of Prescription, it is Waived

The Court of Appeals of Louisiana affirmed the decision that a trial court properly ordered prescription issues to be determined by a trial court. The delay to object to the trial court’s decision is a waiver.

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156 See id.
157 See id. at 715.
158 See id. at 716-17.
159 See id. at 716.
160 See id. at 719.
161 See Humana, 119 S.Ct. at 716.
162 See Humana, 119 S.Ct. at 718.
163 See id. at 718.
164 See id. at 719.
A hemophiliac commenced judicial action against a blood derivative manufacturer. Plaintiff claimed he acquired HIV from the manufacturer's product. A pre-trial order mandated any preliminary motions must be filed within forty-five days of trial. The issue at hand was whether the trial court retained the task of determining prescription to issues.

As previously stated, failure to present an objection to the trial court procedure comprises a waiver. Prior case law held that even if there was a justified reason for the delay, prescription issues are accurately tried by the court, not the jury. Furthermore, the trial judge is perfectly capable of handling such a matter. Therefore, the right was waived and the trial court will try the prescription issues. Doe v. Cutter Biological, 727 So. 2d 1187 (La. Ct. App. 1999).

MEDICAL MALPRACTICE

Physician and Department Clinic Are Held Immune Under Governmental Immunity Act

The Colorado Court of Appeals reversed a lower court ruling that a defendant physician volunteering part time at a public clinic was not a public employee and lacked immunity under the Colorado Governmental Immunity Act (GIA). The court also reversed the lower court's refusal to dismiss the claim against the County Department of Health and Environment, finding the clinic was a public hospital under the GIA, and thereby did not waive its immunity.
The patient brought a negligence claim against the physician for failure to diagnose breast cancer in a timely manner. The physician claimed that he was a "public employee" under the GIA since he volunteered at a community-sponsored clinic part time. As a "public employee" under the GIA, the physician asserted immunity as a defense to the patient's claims. The patient also claimed that the Department was liable under the theory of respondeat superior. The Department claimed the clinic was not a hospital under the GIA, thereby retaining immunity in an action seeking compensation for injuries.

The court held that the physician was considered a "public employee" according to the GIA, and was entitled to assert immunity as a defense to any malpractice claims. The physician was considered a public employee since he treated the patient within the scope of his duties as a part time volunteer at the clinic.

Furthermore, the court held that the clinic was not a hospital according to the GIA. The court looked at the intent of the lawmakers as well as the common meaning of "hospital" and "clinic." The clinic lacked inpatient services, therefore, it did not meet the meaning of the term "hospital" under the GIA. Because the court dismissed the plaintiffs' complaints on the basis of subject matter jurisdiction, the court offered no decision regarding the liability claim against the Department under the theory of respondeat superior. Plummer v. Little, 1999 WL 21339.

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203 See id. at *1.
204 See id.
205 See id.
206 See Plummer, 1999 WL 21339, at *1.
207 See id.
208 See id. at *3.
209 See id. at *2.
210 See Plummer, 1999 WL 21339 at *3-4.
211 See id. at *4.
212 See id. at *5.
Physician Breached Duty to Provide a Second Informed Consent, Causing Substantial Injury to a Newborn Child

The Supreme Court of Wisconsin affirmed the decision that a physician violated a patient's right of informed consent by neglecting to initiate another informed consent discussion when patient's circumstances substantially changed by withdraw of consent to deliver her baby vaginally.\(^{219}\)

Patient was in labor with her third child.\(^{220}\) Her previous pregnancies resulted in cesarean deliveries.\(^{221}\) However, plaintiff and physician had thoroughly discussed the possibility of vaginal birth after cesarean (VBAC) and plaintiff consented to that strategy.\(^{222}\)

As plaintiff's labor progressed, she experienced immense abdominal pain.\(^{223}\) As a result, she changed her mind and wanted to have a cesarean delivery.\(^{224}\) She repeatedly informed her physician of the desire for a cesarean delivery.\(^{225}\) The physician was unable to determine the source of the abdominal pain, and he advised plaintiff to continue with the VBAC.\(^{226}\)

However, after the baby's heart rate plummeted and the physician conducted an emergency cesarean.\(^{227}\) The cesarean delivery was not done in time; the uterus ruptured and the baby was deprived of oxygen, causing the baby to be born a spastic quadriplegic.\(^{228}\)

The parents sued the physician for negligently misdiagnosing plaintiff's abdominal pain, and violating patient informed consent rights, but eventually the negligence claim was dropped.\(^{229}\)

The circuit court held that a physician does not need to seek new consent unless there was a significant change in the patient's medical

\(^{219}\) See Schreiber v. Physicians Ins. Co. of Wis., 588 N.W.2d 26, 27-28 (Wis. 1999).

\(^{220}\) See id. at 28.

\(^{221}\) See id.

\(^{222}\) See id.

\(^{223}\) See id.

\(^{224}\) See Schreiber, 588 N.W.2d at 28.

\(^{225}\) See id. at 29.

\(^{226}\) See id.

\(^{227}\) See id.

\(^{228}\) See id.

\(^{229}\) See Schreiber, 588 N.W.2d at 29.
Furthermore, informed consent must do more than explain the methods available to the patient. Informed consent must obligate the physician to carry out these wishes as long as treatment is possible, reasonable, or viable.

Here, the patient’s repeated proclamation to have a cesarean section delivery constituted a withdrawal of consent to a VBAC, which was a significant change in the patient’s circumstances. Since consent for VBAC was withdrawn the physician was obligated to initiate another informed consent discussion. Again, this informed consent discussion should include the benefits and risks of the medical alternatives. The physician finally stated that he would have fulfilled her wish had she pursued it.

The objective test is applied to typical informed consent cases. There is an issue as to whether or not the patient was given enough information to make an informed decision. However, in this case, the issue is whether or not patient had the chance to make the choice, which elicits a subjective test. Applying the subjective test, that the patient would have chosen cesarean section if she had the choice.

When the patient withdrew her original consent to carry out the VBAC there were still alternative, feasible options. As a result, the physician had a duty to initiate another consent discussion. Seeing that this discussion never took pace, plaintiff was deprived of her first choice of treatment, a cesarean delivery which let to her child’s irreversible injuries. Schreiber v. Physicians Ins. Co. of Wis., 588 N.W.2d 26 (Wis. 1999).

230 See id.
231 See id.
232 See id.
233 See id. at 31.
234 See Schreiber, 588 N.W.2d at 32.
235 See id. at 32-3.
236 See id. at 33.
237 See id.
238 See id. at 34.
239 See Schreiber, 588 N.W.2d at 34.
240 See id.
241 See id. at 35.
242 See id.
243 See id.
Hospital Pharmacist Has No Duty to Warn Patients of Potential Adverse Side Effects of Medications

The Court of Appeals of Washington affirmed a lower court decision, which granted summary judgement for a hospital in a negligence claim and entered a verdict for a physician in a medical malpractice claim. The court held no duty to warn existed with follow up hospital personal since such a duty would interfere with the physician/patient relationship.

Following an injury to a toe the plaintiff entered a hospital for treatment and was prescribed indomethacin, an anti-inflammatory medication by the examining physician. He then received instructions regarding the drug from a discharge nurse. Finally, he received the medication from the hospital pharmacist. After taking the prescribed medication, the plaintiff suffered a pulmonary hemorrhage since he was also taking heparin for a blood clotting condition. Although the hospital staff testified that it was generally known that a combination of heparin and indomethacin may cause adverse reactions, the plaintiff was given no warning of this other than written instructions given to him by the discharge nurse.

The three issues analyzed up by the court were whether the examining doctor was liable for prescribing a drug which caused a negative reaction with the plaintiffs previous medication, whether the discharge nurse had a duty to warn the plaintiff of a risk of possible negative side effects of a drug prescribed at a hospital, and whether a hospital pharmacist had a similar duty with respect to the medication administered.

The court found the hospital pharmacist did not have a duty to warn the plaintiff of the risk of adverse reactions by combining heparin and

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245 See id. at 794-96.
246 See id. at 793.
247 See id.
248 See id.
249 See id., 970 P.2d at 793.
250 See id. at 790-94.
251 See id. at 793-96.
According to the court, since there was no absolute error in combining these drugs the pharmacist was not acting out of negligence when filling the prescription. The court noted that while a pharmacist does have a duty to correctly fill a prescription, the institution of an additional obligation to warn would transform the pharmacist/patient relationship into a physician/patient relationship. This was unfair since these judgements concerning medications properly rest with the physician.

The court also held the hospital discharge nurse was not negligent in failing to inform the plaintiff of possible material risk for drug interactions. With respect to the situation involving the discharge nurse the court drew a parallel to the discussion involving the pharmacist. The court concluded that the weighing of material risks of this nature more properly rested in the hands of the physician. Thus, to hold the discharge nurse negligent would, in effect, interfere with the relationship between the physician and the patient. Similarly, the court declined to find the discharge nurse negligent for failing to review the written instructions with the plaintiff, since such a decision would impose a duty on the discharge nurse to review all written instructions with all patients. This decision was based on the fact that patients could easily read the instructions and, in fact, were asked to sign a statement attesting to the fact that the instructions were read and understood.

With respect to the issue of whether the lower court properly found in favor of the physician, the court held the lower court did not err in failing to admit the plaintiffs prior medical records which included an evaluation of whether the plaintiff was fit to return to work. The court held that since this record was irrelevant to the plaintiff's medical diagnosis it was not admissible under a medical records exception.

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252 See id. at 794.
253 See id.
254 See Silves, 970 P.2d at 794.
255 See id.
256 See id. at 795.
257 See id.
258 See id. at 796.
259 See Silves, 970 P.2d at 795.
260 See id.
261 See id. at 796.
262 See id.
263 See id.
Since this was the only issue, which the plaintiff raised on appeal with respect to the count of malpractice against the physician the court held the lower court properly found in favor of the physician in the trial below. 264

MEDICARE/MEDICAID

Failure to Provide Medicaid Benefits for Sex Change Operation May Violate Due Process Clause of Fourteenth Amendment

The United States District Court for the Northern District of Iowa held a Medicaid recipient was entitled to bring an action under 42 U.S.C. § 1983 and the Fourteenth Amendment’s due process clause based on a denial of his request for Medicaid benefits for sex reassignment surgery. 265

The state of Iowa participates in the joint federal-state Medicaid program under Title XIX of the Social Security Act pursuant to a state plan approved by the Secretary of the Department of Health and Human Services. 266 Plaintiff requested payment for sex reassignment surgery from the Iowa Medicaid program. 267 Under the state plan, reconstructive or plastic surgery is not covered by the program. 268 While sex reassignment surgery was excluded from the general rule of no coverage for reconstructive surgery initially, it was also later excluded in 1994 as a covered surgery based on a literature review indicating continuing controversy regarding sex reassignment surgery as a treatment for gender dysphoria. 269 Gender dysphoria is the belief that one is imprisoned within a body incompatible with one’s real sexual identity. 270 Based on a 1994 amendment to the state plan, the plaintiff’s request for payment was denied. 271 On May 17, 1997, plaintiff filed a compliant pursuant to 42 U.S.C. § 1983 and the due process clause of the Fourteenth Amendment

264 See Silves, 970 P.2d at 797.
266 See id. at 957.
267 See id.
268 See id.
269 See id.
270 See Smith, 24 F. Supp. 2d at 957.
271 See id.
alleging a violation of the federal Medicaid statute 42 U.S.C § 1396 et seq. On June 1, 1998, defendant filed a motion for summary judgment on the grounds plaintiff’s allegation of a violation of the federal Medicaid statute and its regulations failed to state a cause of action under 42 U.S.C. § 1983 and plaintiff’s allegation of violation of the due process clause was without merit.

The court found plaintiff stated a proper cause of action under 42 U.S.C. § 1983 because a genuine material issue of fact existed as to whether sex reassignment surgery was a medically necessary treatment for plaintiff’s gender dysphoria. Additionally, the court found plaintiff stated a proper cause of action under the Fourteenth Amendment’s due process clause since the state’s Department of Health and Human Services’ reliance on a private physician’s literature review as a reasonable exercise of its discretion in implementing regulations for excluding sex reassignment surgery created a genuine issue of material fact. As a result, the court denied defendant’s motion for summary judgment. Smith v. Palmer, 24 F. Supp. 2d 955 (N.D. Iowa 1998).

Establishment of a Special Needs Trust Did Not Affect State Medicaid Agency’s Right to Reimbursement Upon Settlement with Third Party Tortfeasors

The Superior Court of New Jersey, Appellate Division, in a trial which combined two similar cases, reversed two lower court decisions and held a state Medicaid agency was entitled to recover the full amount of benefits paid out to plaintiffs after they were awarded a judgement against third party tortfeasors. The court reached this conclusion even though special needs trusts were in place in behalf of the recipients.

Both plaintiffs suffered injuries due to malpractice and received Medicaid benefits to assist in their treatment. Subsequently both

272 See id. at 956.
273 See id.
274 See id. at 957.
275 See Smith, 24 F. Supp. 2d at 968.
276 See id. at 969.
278 See id. at 585.
279 See id. at 583.
plaintiffs were awarded settlements in their malpractice cases and a portion of the settlements were put into special needs trusts for the benefit of the plaintiffs. The plaintiffs were notified by the state Medicaid agency that they were obligated to contact the agency prior to settlement of their claims so that a lien amount could be established.

In both cases the lower courts declined to allow the state Medicaid agency to collect part or all of the amount previously expended in benefits. In one case the lower court reasoned federal Medicaid law preempted state law and thereby precluded a state from establishing a lien on funds that properly paid for medical assistance prior to a person’s death. The state could only obtain monies from a trust after the death of the recipient. The second case differed only in that the lower court limited the state Medicaid agency to place a lien on the portion of the trust connected to the plaintiff’s medical expenses and exempted the portion connected to the plaintiffs “future needs.”

Plaintiffs in these cases argued that federal Medicaid law states that special needs trusts are outside of the realm of recoverable finances when a Medicaid lien is being established. The court disagreed with this interpretation and pointed out that while certain trusts are not taken into consideration when determining financial eligibility for Medicaid, it does not follow that these trusts are outside of the reach of Medicaid liens when the situation involves recovery from third party tortfeasors. The reason certain trusts are not considered in determining Medicaid eligibility is so that a beneficiary may maintain funds while still being able to obtain Medicaid benefits. The court stated that ideally a Medicaid lien should be imposed prior to the institution of a trust. Thus, the Medicaid lien is actually against the finances of the third party tortfeasors and not the Medicaid recipient.

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280 See id.
281 See id. at 582-83.
282 See Waldman, 722 A.2d at 583.
283 See id.
284 See id.
285 See id. at 584.
286 See id.
287 See Waldman, 722 A.2d at 586.
288 See id.
289 See id.
290 See id. at 585, 586.
The court found the holdings of the lower courts were invalid due to the fact that by the reasoning posited below, a recipient of Medicaid benefits could avoid having to reimburse the state agency simply by setting up a special needs trust. This reasoning goes against the spirit of the complementary state and federal Medicaid laws, which are in place to provide medical assistance to those who are seriously in need. Thus, the court concluded because the plaintiffs in these cases received Medicaid assistance when it was needed by the respective state and federal agencies those agencies were entitled to fully recover when the claims were settled.


MENTAL HEALTH

Order for Involuntary Administration of Medication Struck Down Due to a Lack of Specific Statement of Type and Dosage of Medication

The Appellate Court of Illinois for the Second District reversed the judgement of the lower court that authorized an order calling for involuntary administration of psychotropic medication by the State of Illinois. The court found reversal was appropriate since the state's petition had not alleged a good-faith determination on whether the respondent had executed an advance health care directive; that the state made no attempt to prove that the respondent would have consented to the medication if he were competent; and that the order did not specify the type or dosage of medication to be administered.

The state petitioned for involuntary administration of medication for the respondent based on the testimony of a psychiatrist at the mental health facility at which the respondent was undergoing treatment. The psychiatrist diagnosed the respondent with psychosis and stated the

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291 See id. at 586.
292 See Waldman, 722 A.2d at 586.
293 See id. at 587.
295 See id. at 104-08.
296 See id. at 106.
respondent did not have the capacity to make a decision regarding the administration of his medication. The psychiatrist further testified that the benefits of the medication would outweigh any negative side effects. The court found a procedural error was created when the state failed to allege a good-faith determination on whether an advance health care directive had been executed by the patient. However, the court concluded this procedural error was harmless due to the fact that it should have been obvious at the time the pleading was filed and if the respondent had objected in the trial court it would have been easily corrected.

Secondly, the court held the "substituted judgement standard" was not inaccurately applied. The substituted judgement standard is a devise by which a surrogate decision maker attempts to establish the decision the respondent would have made were he competent. The court noted an objective standard of reasonableness is appropriate when the wishes of the patient were not clearly proven and that this objective standard should be based on evidence actually presented.

Thirdly, the court decided the order granting involuntary administration should be reversed due to the fact that the State failed to specify the particular drug and the dosage to be administered. The court based this decision on the fact that the Mental Health and Developmental Disabilities Code explicitly mandates that the order specifically state the type and amount of medication to be administered. The fact that the respondent failed to raise this issue at the trial did not preclude a ruling on it since it was not merely a procedural defect but is also an element of the substantive right of the patient. The court emphasized the exact kind of medication was essential in showing that the benefits of the medication would be greater than any adverse effects. In re Len P., 706 N.E.2d 104 (Ill. App. Ct. 1999).
Liability Under EMTALA Requires Plaintiff to Be Physically Present

The United States District Court for the district of Hawaii held a patient cannot sue a hospital under the Emergency Medical Treatment and Active Labor Law (EMTALA) for liability that arises when the patient was not physically on the hospital premises. 303

On May 5, 1996, the plaintiff patient experienced difficulty breathing while on his way to work. 309 When the ambulance arrived plaintiff was in severe respiratory distress. 310 The ambulance drove him to the nearest medical facility, which was defendant Queen’s Medical Center. 311 En route, the ambulance personnel spoke by radio with defendant physician of Queen’s Medical Center about plaintiff’s condition. 312 Defendant physician inquired as to who plaintiff’s physician was and was told that plaintiff was a Tripler Hospital patient. 315 Defendant physician instructed the ambulance personnel to initiate treatment and take the patient to Tripler Hospital, located five miles from Queens. 314 The patient experienced cardiopulmonary arrest two minutes after arriving at Tripler, and died twenty-four minutes later. 315

Plaintiffs sued under the EMTALA alleging negligence. 316 Because physical presence is required in order to trigger EMTALA liability, the court found no liability, and affirmed the findings of the district court. 317


309 See id.
310 See id.
311 See id.
312 See id.
314 See id. at *3.
315 See id.
316 See id. at *4.
317 See id. at *9-14.
The Purpose of EMTALA is to Assure Emergency Treatment to Those Who Need it, Not to Ensure Patient is Transported to the Hospital of Choice

The United States District Court for the Southern District of Texas granted summary judgment for defendant hospital charged with violating the Emergency Medical Treatment and Active Labor Act (EMTALA) when an unconscious patient was transported to one hospital despite the patient’s supervisor’s instruction to transport the patient to another hospital. [318]

Defendant filed a summary judgment motion because plaintiff did not meet requirements of EMTALA by properly presenting himself to defendant. [319] Also, defendant claimed not to be responsible for fulfilling supervisor’s instructions to transport patient to another hospital. [320]

Plaintiff was injured on the job and was unconscious when the ambulance arrived. [321] Defendant’s ambulance company answered the call. [322] Plaintiff’s supervisor instructed the ambulance drivers to take the patient to Mission Hospital. [323] However, the patient was taken to Starr County Hospital, which was owned by the ambulance company. [324] Plaintiff claimed defendant violated EMTALA by not fulfilling employer’s request to take the patient to Mission Hospital. [325]

EMTALA requires that the patient “comes” to the emergency department. [326] The court held plaintiff did not fail to meet the requirements of EMTALA because he did “come” to the hospital emergency room. [327] A federal district court ruled that a patient arrives at

[319] See id. at 972.
[320] See id.
[321] See id.
[322] See id.
[324] See id.
[325] See id. at 972.
[326] See id.
[327] See id. at 973.
an emergency room when he or she enters the ambulance owned by that hospital. Thus plaintiff adequately met EMTALA's requirements.

However, the court ruled defendant did not violate EMTALA by transporting patient to a hospital different from the one requested. The purpose of EMTALA was to ensure that all in need of emergency treatment receive it, not to decipher to which hospital the patient should be transported. Hernandez v. Starr County Hosp. Dist., 30 F. Supp. 2d 970 (S.D. Tex 1999).

PRIVACY

Patient Failed to Establish Violation of Privacy Arising From a Physician's Disclosure of the Patient's Medical Condition

The Supreme Court of Hawaii held a physician did not violate patient's right to privacy when the physician disclosed his diagnostic impressions of the patient's medical condition to a federal prosecutor. The prosecutor had been ordered to secure the patient's examination after patient checked into hospital rather than appear for criminal trial.

On August 13, 1994, plaintiff was charged with three counts of willfully failing to file federal income tax returns in violation of 26 U.S.C. § 7206. Plaintiff's trial was scheduled to start on September 13, 1994. At the time of the scheduled trial, the Assistant United States Attorney informed the district court of plaintiff's hospitalization on the previous night for back problems. The court immediately ordered the United States Attorney's Office to have a physician examine plaintiff. When the United States Attorney contacted the hospital to make arrangements

See Hernandez, 30 F. Supp. 2d at 973.
See id.
See id.
See id.
See id.
See id.
See id.
See id.
for the examination, he was advised plaintiff had already been discharged on the grounds he had no physical condition warranting a continued stay in the hospital. Based on this information, the district court found plaintiff was physically and mentally fit to participate in the trial and immediately issued a warrant for the plaintiff’s arrest. On December 19, 1996, plaintiff filed an amended complaint against the physician and the hospital, alleging, among other things, breach of patient-physician relationship. On January 7, 1997, the physician filed a motion to dismiss plaintiff’s amended complaint on the grounds the patient waived any right of confidentiality by putting his medical condition at issue when he checked into the hospital the night before his scheduled criminal trial. Therefore, the disclosure was permissible pursuant to the provisions of Hawaii’s Rules of Evidence (HRE) 504(d)(2).

The court held while a physician owes a duty not to release confidential information from the patient’s medical records without express written permission, the privilege was not absolute. The court noted, even according to HRE 504, four exemptions including medical examination ordered by the court, are not privileged physician-patient communications. Thus, after finding no distinction between the court ordering the examination or receiving information from an examination already performed, the court held the physician did not violate the patient’s right to privacy. Dubin v. Wakuzawa, 1998 WL 824549 (Haw. Dec. 1, 1998).

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338 See id.
339 See id.
340 See id.
341 See id.
343 See id. at *6.
344 See id.
345 See id. at *9.
PROCEDURE

Judges Are Not the Proper Defendants in a Suit Challenging the Constitutionality of an Act Allowing Parents to Petition for a Court Order to Commit Their Children to Drug Treatment Programs

The United States District Court for the Eastern District of Pennsylvania granted the defendants' motion to dismiss the plaintiffs' constitutional challenge of a state act allowing parents or guardians to petition for a court order to involuntarily commit their children to drug and alcohol treatment programs. The court dismissed the claim against three judges who presided over the state actions involving the plaintiffs, ruling that the judges were not the proper defendants.

The plaintiffs, as minors whose parents sought a court order for their involuntary commitment to a substance abuse program, claimed the commitment was unconstitutional on due process and equal protection grounds. The plaintiffs contended the judges, as enforcers of the statute, were the proper defendants since under the act they had to act with interests adversarial to the plaintiffs' motives. Furthermore, the judges adversarial interests created a case or controversy according to Article III of the Constitution.

The court held that the judges were improper defendants in this suit because they lacked either a personal or institutional stake in the controversy. The court also found that judges played no role in the passing of the statute, nor were they initiators of the enforcement or subsequent actions taken against the minors. The parents were the parties that initiate the judicial determination, while the judges only acted in their adjudicatory capacity. The court concluded that the judges were

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347 See id. at *1.
348 See id. at *3.
349 See id.
350 See id.
351 See Brandon E., 1999 WL 98585, at *4.
352 See id. at *6.
353 See id.
making their decisions for each case only on the merits of the cases before them, and were not acting in any administrative capacity. Because the judges were only making neutral determinations in the case and basing their decisions in each case solely on the merits of each case, the judges are not the proper defendants in this suit. Thus, the plaintiffs failed to state a claim for which relief may be granted. Brandon E. v. Reynolds, No. Civ. A.98-4236 (Pa. Feb 25, 1999)(1999 WL 98585 (E.D. Pa.)).

State Claims Not Preempted by ERISA Cannot Be Removed

The United States District Court of New Mexico reversed the decision to remove a case because the claims do not arise under Employee Retirement Income Security Act of 1974 (ERISA). To be preempted the claim must be directly related to the benefits pursuant to the benefits plan.

Plaintiff patient filed a medical malpractice suit in the state court system to recover from injuries sustained from a vasectomy. The claim consisted of four counts: medical malpractice by the physician and vicarious liability by the health care system; corporate negligence resulting form the health care system’s lack of monitoring patient care and supervision of the physicians; negligence per se against defendant for infractions of medical facilities’ standard of care; and intentional infliction of emotional distress. Shortly thereafter defendant health care system commenced action for removal to a federal court because plaintiff’s claims were preempted by ERISA, due to the claims pertinent to the HMO benefits plans. Defendant stated that these claims were preempted and could be tried in a federal court. Plaintiff disagreed and asserted that his claims did not arise under ERISA, instead, the claims were medical

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354 See id.
355 See id.
356 See Brandon E., 1999 WL 98585, at *8.
358 See id. at 1330.
359 See id. at 1328.
360 See id.
361 See id.
362 See Herrera, 35 F. Supp. 2d at 1329.
malpractice and negligence.\textsuperscript{363} These later claims were state law causes of action, which were not completely preempted.\textsuperscript{364}

According to the Supreme Court, complete preemption applies in two circumstances: when claims fall under either the National Labor Management Relations Act or section 502 of ERISA.\textsuperscript{365} In ERISA, a claim is only preempted when the claim pertains to an action to recover benefits per the insurance plan.\textsuperscript{366}

There has been much inconsistency as to whether or not a medical incident that is incorrectly rejected by an HMO is completely preempted.\textsuperscript{367} However, the majority of the courts have ruled that such claims were not preempted for several reasons.\textsuperscript{363} First, when medical malpractice and vicarious liability claims would be resolved without referring back to the insurance plan, such claims were not preempted.\textsuperscript{369} More specifically, medical malpractice and vicarious liability were not to enforce benefits, rather they were disputing administration of benefits or enforcing privileges of the plan.\textsuperscript{370} Therefore they were not preempted.\textsuperscript{371} Second, medical malpractice and vicarious liability claims do not attack the benefits themselves, but rather the quality of the benefits.\textsuperscript{372} ERISA mandates that benefits be provided.\textsuperscript{373} It never specified the quality of the benefits.\textsuperscript{374} Third, if the claims (such as medical malpractice or vicarious liability) can be rectified without analyzing the benefits contract, then the claim was not preempted.\textsuperscript{375} Finally claims pertaining to negligent supervision by the HMO were not preempted.\textsuperscript{376} Thus because the actual plan was immaterial to the claim, they were not preempted by section 502 of ERISA.\textsuperscript{377} \textit{Herrera v. Lovelace Health Sys., Inc., 35 F. Supp. 2d 1327(D.N.M. 1999)}.

\textsuperscript{363}See id.
\textsuperscript{364}See id. at 1329.
\textsuperscript{365}See id. at 1330.
\textsuperscript{366}See id.
\textsuperscript{367}See \textit{Herrera}, 35 F. Supp. 2d at 1331-32.
\textsuperscript{368}See id.
\textsuperscript{369}See id.
\textsuperscript{370}See id. at 1331.
\textsuperscript{371}See id.
\textsuperscript{372}See \textit{Herrera}, 35 F. Supp. 2d at 1332.
\textsuperscript{373}See id.
\textsuperscript{374}See id.
\textsuperscript{375}See id.
\textsuperscript{376}See id.
\textsuperscript{377}See \textit{Herrera}, 35 F. Supp. 2d at 1332.
Removal to Federal Court Improper
Where a Disability Insurance Plan
Covered Only Employer

The United States Court of Appeals for the Eleventh Circuit reversed a lower court decision in favor of insurance company and held removal to federal court was improper since it was not preempted by the Employee Retirement Income Security Act of 1974 (ERISA). The court refused to interpret ERISA to cover insurance plans purchased solely for a single employer where the employer also purchased additional plans for employees.

Plaintiff, a physician, initially brought suit in Circuit Court when defendant insurer failed to pay benefits of the disability policy. Following this filing, the defendant insurer succeeded in removing the case to federal court on the basis that the claim was properly governed by the ERISA. Subsequently, plaintiff was denied remand of the case back to state court but allowed to amend the original complaint to include an ERISA claim. Eventually a decision was handed down in which the defendant insurer prevailed and the plaintiff appealed.

The plaintiff solely owned a dental practice and provided health insurance for himself and his employees. Since the plan lacked disability benefits, the plaintiff purchased a separate, additional disability insurance policy for himself and made payments on it in the name of the corporation. When the plaintiff attempted to collect on the disability policy, the defendant, insurer argued that the claim should be brought in federal court under ERISA. The issue the court considered was whether the claim was, in fact, governed by ERISA.

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379See id. at 1105-06.
380See id. at 1104.
381See id.
382See id.
383See Slamen, 166 F.3d at 1104.
384See id. at 1103.
385See id.
386See id. at 1104.
387See id. at 1103-1104.
The court held the claim was not covered by ERISA. Five elements are considered in a determination of whether a plan is under ERISA. There must exist

(1) a plan which is
(2) set up
(3) by an employer
(4) to provide medical treatment and disability benefits to
(5) those participating in the plan.

The court held the disability benefit plan did not satisfy these criteria because the physician was not participating in the plan within his employee status. Therefore, this plan did not technically cover any employees, and, as such, could not be deemed to be covered under ERISA. The court clarified this to mean at least one employee, outside of an employer who also owns the business, must be participating in the plan for it to be covered under ERISA. In this case the plaintiff was the only one participating in the disability benefits package. By virtue of the fact that the plaintiff was the only participant receiving benefits under the plan, he did not properly fit within this definition.

The defendant insurer posited that since the plaintiff had in place other benefit packages which did apply to all employees, the disability plan should have been seen as merely one part to a consolidated benefit package. Thus the consolidated package was covered under ERISA because, taking it as a whole, numerous employees were participants. The court, however, did not give merit to this argument and stated that a plan would not be deemed part of an ERISA plan solely by virtue of the fact that an employer contemporaneously offers other plans to employees. Since the claim was not properly an ERISA claim no

See Slamen, 166 F.3d at 1104.
See id.
See id. (quoting Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982) (en banc))
See id. at 1106.
See id.
See Slamen, 166 F.3d at 1102.
See id. at 1105.
See id.
See id.
See id.
See Slamen, 166 F.3d at 1105.
federal question was involved and, thus, the case was originally improperly removed to federal court.\footnote{399}{Slamen v. Paul Revere Life Ins. Co., 166 F.3d 1102 (11th Cir. 1999).}

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**PRODUCT LIABILITY**

Statute of Repose Extinguished
Plaintiffs' Cause of Action

United States Court of Appeals for the Second Circuit held the Statute of Repose extinguishes the cause of action, regardless of when the cause of action accrued.\footnote{400}{In May, 1979, Plaintiff Pamela Craven retained an attorney, Daniel Cullen, to pursue her minor son's (Brian Craven's) legal rights with respect to the vaccine-induced polio that had left him permanently paralyzed at the age of three months.\footnote{401}{Although he informed her 'she had a case,' no suit was commenced against Cyanamid, the manufacturer of the vaccine.\footnote{402}{Eleven years later, Craven retained a new attorney, who on September 27, 1990, filed a petition on Brian's behalf in the United States Court of Claims under the National Childhood Vaccine Injury Compensation Act of 1986 (VCA).\footnote{403}{In 1994, Mrs. Craven changed counsel again.\footnote{404}{Acting on the advice of new counsel, she withdrew the VCA petition on November 25, 1994, leaving no pending action on her son's behalf.}}}}}}}

The second plaintiff, Michella Kairdolf, sustained vaccine-induced polio with attendant paralysis in 1982, three months after birth.\footnote{405}{The Kairdolfs filed a petition on behalf of their minor daughter under VCA on \footnote{406}{See id. at *5.}}

On June 2, 1995, both plaintiffs commenced a putative class action in United States District Court for the Southern District of New York against Cyanamid and its parent corporation. In Craven’s case, the statute of repose in Nebraska (birthplace of first minor plaintiff) barred all product liability commenced more than ten years after the product’s sale “notwithstanding any other statutory provision to the contrary.” Additionally, Craven’s cause of action for breach of express warranty under U.C.C. 2-725 (which is specifically exempted from Nebraska’s statute of repose) was barred because it must be commenced within four years after the cause of action has accrued. In the Kairdolfs’ case, the parties stipulated the Louisiana laws of prescription (i.e. statute applied because second minor plaintiff was born in Louisiana). A one-year time limit under Louisiana’s prescription rule applies when a causal connection between the product and the injury is immediately discoverable. The court found that the Kairdolfs had notice of the causal connection between Cyanamid’s vaccine and minor plaintiff’s polio no later than March 1987. The prescription period expired in March 1988, seven years before plaintiffs brought suit.

On September 21, 1998, the appellate court affirmed the district court’s ruling granting Cyanamid’s motion for summary judgment, citing both claims as being time-barred under their respective state’s statutes.


407 See id.
408 See id.
409 See id.
411 See id. at *22.
412 See id. at *19.
413 See id. at *12.
414 See id.
Records and Board of Directors Meetings of Hospital Are Subject to Public Access Laws Despite the Fact That the Hospital was Leased By Private Not-for-Profit Organization

The Supreme Court of Florida affirmed a lower court’s decision that records and minutes from board of directors meetings for a defendant not-for-profit hospital were statutorily subject to the Public Records Act and the Sunshine Law. The plaintiff corporation filed a complaint seeking such records be open to the public. The court reached its decision even though the public hospital had been leased to a private not-for-profit corporation to operate the hospital for the district’s residents.

The court held that the state constitution’s provision requiring public access to records applied, since the hospital’s assets were from bond issuances and tax receipts. Therefore, the court found the public should have access to the records for the purpose of scrutiny. Furthermore, a totality of factors demonstrated that the hospital, despite being leased to a private corporation, was still acting on behalf of the public hospital agency, serving the needs of the district’s residents. The private corporation had been delegated authority to run the hospital only on an interim basis. Also, there was no evidence that the legislature had followed any of the express procedures to exempt the hospital from the public records access law.

The court also found that the hospital’s board of directors meetings were subject to the open meeting requirements of the constitution and the Sunshine law. Because the board of directors were acting on behalf of

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417 See Memorial Hosp.-West Volusia, Inc. v. New-Journal Corp, 729 So. 2d 373, 380 (Fla. 1999).
418 See id. at 375.
419 See id. at 377.
420 See id. at 380.
421 See id.
422 See Memorial Hosp.-West Volusia Inc., 729 So. 2d at 379-80.
423 See id.
424 See id.
425 See id. at 382.
the public body in running the public hospital’s business, the directors meetings were constitutionally required to be open to the public.\textsuperscript{426} 

Public access to records and minutes from board of director meetings followed the transfer of authority to function, regardless of any leasing arrangements between the public hospital and the private not-for-profit corporation.\textsuperscript{427} Therefore the lower court holding requiring the disclosure of records of the hospital and open meetings was affirmed. \textit{Memorial Hosp.-West Volusia, Inc. v. New-Journal Corp.}, 729 So. 2d 373 (Fla. 1999).

\section*{TORTS}

\textbf{A Fund That Covers An Insolvent Insurance Company is Not Liable for Tort Damages and Cannot Be Charged With Bad Faith for Failing to Pay Those Tort Damages}

The Court of Appeals of Arizona affirmed a partial summary judgment favoring defendant insurance fund that assumed all covered claims for an insolvent insurance company.\textsuperscript{428} This ruling deemed any tort damages outside the definition of covered damages, and bad faith liability is not applicable.\textsuperscript{429}

Plaintiff’s husband died and she filed a wrongful death suit against a company whose insurance company went bankrupt.\textsuperscript{429} Defendant then assumed financial responsibility for the insolvent company.\textsuperscript{431} However, the insurance fund refused to cover or settle the situation involving plaintiff.\textsuperscript{432}

According to state statute the defendant claimed that it enjoyed immunity from such tort claims.\textsuperscript{433} Defendant’s purpose was to assume

\begin{footnotesize}
\textsuperscript{426}See id. at 383.
\textsuperscript{427}Memorial Hosp.-West Volusia, Inc., 729 So. 2d at 380.
\textsuperscript{429}See id. at *8, *10.
\textsuperscript{430}See id. at *1.
\textsuperscript{431}See id.
\textsuperscript{432}See id.
\textsuperscript{433}See Bills, 1999 WL 53050, at *1.
\end{footnotesize}
covered claims of insolvent insurers.\textsuperscript{434} A covered claim was an unpaid claim that originated out of a coverage of the policy of the insolvent insurance company.\textsuperscript{435} As a result, defendant had a direct relationship with the insured pursuant to the terms and conditions of the policy and the state statute.\textsuperscript{436} Good faith was implicit in this new relationship.\textsuperscript{437}

When statutory language is unclear the court must turn to the legislative intent and relevant statutory provisions.\textsuperscript{438} Upon further investigation, the court decided that defendant was immune from tort liability pursuant to A.R.S. \textsuperscript{439}Because there were no indications otherwise, the court assumed that there was an oversight when the fund was not expressly included in the statute.\textsuperscript{440} Thus, the court held that defendant was limited to covered claims, not including tort claims.\textsuperscript{441}

Courts decided if companies were not immune from bad faith it would destroy the power of the immunity provision.\textsuperscript{442} Furthermore, since defendant was not responsible for tort claims, there can be no bad faith charges for failing to compensate for tort claims.\textsuperscript{443} Finally, the only way a bad faith claim would be acceptable was if defendant handled covered claims in bad faith.\textsuperscript{444} However, this allegation was never made.\textsuperscript{445}

Finally plaintiff challenged defendant’s actions with an equal protection claim.\textsuperscript{446} To do so, plaintiff must show that the legislation was irrational or arbitrary.\textsuperscript{447} The court held that plaintiff had failed to do so.\textsuperscript{448} Moreover, the legislation’s limitation of defendant’s ability to cover only covered claims rationally advanced the state legislation’s interest to preserve defendant’s integrity.\textsuperscript{449} Thus the court granted summary judgment for the defendant, holding that defendant is not responsible for

\textsuperscript{434}See id. at *2.  
\textsuperscript{435}See id.  
\textsuperscript{436}See id. at *3.  
\textsuperscript{437}See id.  
\textsuperscript{438}See Bill, 1991 WL 53050, at *1.  
\textsuperscript{439}See id. at *3.  
\textsuperscript{440}See id.  
\textsuperscript{441}See id.  
\textsuperscript{442}See id.  
\textsuperscript{443}See id.  
\textsuperscript{444}See Bill, 1991 WL 53050, at *6.  
\textsuperscript{445}See id. at *4-5.  
\textsuperscript{446}See id. at *8.  
\textsuperscript{447}See id. at *9.  
\textsuperscript{448}See id. at *10.  
\textsuperscript{449}See Bill, 1999 WL 53050, at *6.  
\textsuperscript{445}See id. at *11.
the claims and had not acted negligently in failing to compensate.\textsuperscript{459} \textit{Bills v. Arizona Property & Casualty Ins. Grp., 1999 WL 53050 (Ariz. App. Div. 2).}

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**WORKERS’ COMPENSATION**

False Accusation of Embezzlement Constitutes Abnormal Working Environment, Which Entitles Employees to Workers’ Compensation Benefits

The Commonwealth Court of Pennsylvania reversed a workers’ compensation decision which denied a worker benefits for a psychiatric injury caused by accusation of embezzlement.\textsuperscript{451} Plaintiff was employed as an office manager for a family practice.\textsuperscript{452} While her duties included general office manager tasks, the main task was billing insurance companies.\textsuperscript{453} Plaintiff was the only person in the office with this task.\textsuperscript{454} Problems arose when a particular physician randomly reduced or waived fees for particular patients.\textsuperscript{455} Such inconsistency caused the employee to resign.\textsuperscript{456} However, the employer refused to accept the resignation and employee continued working.\textsuperscript{457} The physician found some mistakes that were potentially made by plaintiff, contacted top level managers, and announced to plaintiff’s coworkers that plaintiff was stealing.\textsuperscript{458}

After appearing in front of the top-level managers, plaintiff maintained her innocence.\textsuperscript{459} As a result of the accusations, the employee encountered extreme emotional distress and depression, in addition to other mental problems.\textsuperscript{460} Her psychiatrist testified that the problem was

\textsuperscript{450}See id.
\textsuperscript{452}See id. at 971.
\textsuperscript{453}See id.
\textsuperscript{454}See id.
\textsuperscript{455}See id.
\textsuperscript{456}See Miller, 724 A.2d at 971.
\textsuperscript{457}See id.
\textsuperscript{458}See id. at 972.
\textsuperscript{459}See id.
\textsuperscript{460}See id.
triggered by a single occurrence.\textsuperscript{461} Despite consultants’ analysis that there was no trace of wrongdoing, the employee was still suspended.\textsuperscript{462}

To prove a mental injury, one must prove either the injury was attributable to a particular event or it developed over a long period of time.\textsuperscript{463} The court held that the audit itself was not atypical or the source of injury; rather objective events such as embezzlement accusation caused plaintiff’s injury.\textsuperscript{464} Testimony by another coworker verified the physician’s constant inconsistencies regarding the billing.\textsuperscript{465} The physician also admitted fear of fraud accusations and stated he needed to protect his reputation.\textsuperscript{466}

The court held that the plaintiff was exposed to abnormal working conditions when an employer accused him of embezzlement when the employer knew the books were already in a state of disarray in order to prevent his own reputation.\textsuperscript{467} Miller v. Workers’ Compensation Appeal Bd., 724 A.2d 971 (Pa. Commw. Ct. 1999).

\begin{center}
Hearing Examiner Required to Consider All Relevant Evidence Concerning Medical Reports When Deciding Eligibility for Disability Claims
\end{center}

The District of Colombia Court of Appeals vacated a hearing officer’s decision denying disability benefits.\textsuperscript{468} The court held the hearing below was deficient and possibly prejudicial since no evidence was presented as to the employer’s physician’s medical report and the relationship between the plaintiff and her own doctor was not analyzed.\textsuperscript{469}

The plaintiff, a food service employee, became injured after a fall on the job.\textsuperscript{470} She was treated by a physician approved by the employer.\textsuperscript{471}

\begin{footnotes}
\item[461] See Miller, 724 A.2d at 973.
\item[462] See id.
\item[463] See id. at 974.
\item[464] See id. at 975.
\item[465] See id. at 972-3.
\item[466] See Miller, 724 A.2d at 977.
\item[467] See id.
\item[469] See id. at 403-05.
\item[470] See id. at 402.
\item[471] See id.
\end{footnotes}
Pursuant to taking a temporary leave of absence she was allotted disability payments. She then returned to work but was subsequently incapacitated by further complications arising out of the fall, and was forced to take an additional leave of absence for which she was denied further disability payments. While on the second leave of absence the plaintiff obtained treatment from a physician of her own choosing. An issue arose when the medical opinions provided by the two physicians differed as to whether the plaintiff's secondary injuries were related to the primary fall. Subsequently, the plaintiff was examined by the defendant's physician who diagnosed the plaintiff as being unable return to work indefinitely. The plaintiff was then terminated from her position.

The issue presented on review was whether the Director of the Department of Employment Services erred in failing to consider three elements of the case including the report of the employer's physician, the plaintiff's relationship with the physician of her choosing, and whether there was proper notice of the secondary injuries when upholding the denial of disability payments.

The court held the report of the defendant's physician was crucial to a determination of whether the plaintiff was eligible for further disability benefits and thus it was a clear error for the hearing examiner not to address this evidence, since it showed a connection between an assessment of the plaintiff's physical condition and her ability to return to work. It was a further error for the Director of the Department of Employment Services to uphold the hearing examiner's determination without consideration of this report.

While the court did not dispute the plaintiff's own physician was not formally approved by the Office of Worker's Compensation, the situation did require careful analysis. Under the Worker's Compensation Laws

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472 See id.
473 See Velasquez, 723 A.2d at 402.
474 See id.
475 See id.
476 See id. at 402-03.
477 See id. at 402.
478 See Velasquez, 723 A.2d at 403.
479 See id. at 403.
480 See id. at 403-04.
481 See id. at 403.
a recipient is allowed to initially choose her physician.\textsuperscript{482} Since there was a question as to whether the plaintiff ever freely chose the first approved physician, there was also a question as to whether plaintiff's obtaining the treatment of her own physician constituted her initial choice or a change in physician.\textsuperscript{483} Thus, the previous ruling which declined to consider this line of reasoning was incorrect.\textsuperscript{484}

The third issue the court addressed was that of notice regarding the secondary injuries.\textsuperscript{485} The court noted that while federal worker's compensation law states that there must be notice within thirty days of a new injury, the fact that notice was absent should not bar a plaintiff from obtaining benefits.\textsuperscript{486} Because the plaintiff notified both the approved physician and her own physician of shoulder pain a determination of whether proper notice was given turned partly on whether her own physician was an appropriate provider.\textsuperscript{487} Thus the court determined all of these issues should have been considered together.\textsuperscript{488} \textit{Velasquez v. District of Columbia Dep't of Employment Servs.}, 723 A.2d 401 (D.C. Cir 1999).

\section*{WRONGFUL DEATH}

\textbf{Hospital and Physician Liable for Wrongful Death Where No Reasonable Steps Taken to Prevent Foreseeable Tragedy}

The Appellate Court of Illinois, Third District, held a psychiatrist and hospital liable under the Wrongful Death Act for the death of a patient, when the patient committed suicide in their care and custody, but was not bereft of reason or insane at the time he took his own life.\textsuperscript{489}

On January 27, 1990, the patient was voluntarily admitted to the psychiatric ward of defendant hospital after taking extra Elavil given to

\textsuperscript{482}See id. at 404.
\textsuperscript{483}See \textit{Velasquez}, 723 A.2d at 404-05.
\textsuperscript{484}See id. at 401-05.
\textsuperscript{485}See id. at 405.
\textsuperscript{486}See id.
\textsuperscript{487}See id. at 405-06.
\textsuperscript{488}See \textit{Velasquez}, 723 A.2d at 406.
him for depression.\textsuperscript{490} The patient, who had been admitted to the same facility five times in the past for attempted suicide, voiced his suicidal ideations to one of the nurses on staff.\textsuperscript{491} The patient was placed on “close supervision” (rather than “suicide watch”) which gave him unmonitored access to numerous potentially dangerous objects.\textsuperscript{492} Shortly after midnight on January 29, 1990, the patient committed suicide by hanging himself with his shoelaces from a showerhead in the bathroom.\textsuperscript{493}

On June 3, 1991, plaintiffs Herbert Winger and Joyce Winger, the parents of the patient, filed a wrongful death suit alleging both the hospital’s negligence and the psychiatrist’s negligence in preventing their son from committing suicide.\textsuperscript{494} The hospital and the psychiatrist moved for summary judgment, relying on plaintiff’s expert’s opinion the patient understood and appreciated his acts, his actions were intentional, and he was not bereft of reason at the time he committed suicide.\textsuperscript{495} The district court granted summary judgment and plaintiffs appealed.\textsuperscript{496}

The appellate court held although a patient is not bereft of reason and may appreciate the consequences of his actions, the physician and hospital could reasonably have foreseen his self-destructive conduct, and were negligent in failing to protect him.\textsuperscript{497} In the instant case, the patient had been admitted to the defendant’s facility five times for suicide attempts in the five previous months prior to his death.\textsuperscript{498} On the day of his admission he had declared his suicidal ideations to one of his nurses.\textsuperscript{499} Accordingly, the court reversed and remanded to the district court for further proceedings and determination by a jury.\textsuperscript{500} \textit{Winger v. Franciscan Med. Ctr., No. 3097-0680, 1998 Ill. App. LEXIS 642, at *1 (Ill. App. Ct. Mar. 11, 1998)}.

\textsuperscript{490}See id. at *3. 
\textsuperscript{491}See id. 
\textsuperscript{492}See id. 
\textsuperscript{493}See id. 
\textsuperscript{494}See Winger, 1998 Ill. App. LEXIS 25429, at *5. 
\textsuperscript{495}See id. at *5. 
\textsuperscript{496}See id. at *6. 
\textsuperscript{497}See id. at *22. 
\textsuperscript{498}See id. at *26. 
\textsuperscript{500}See id. at *3.