



Legal Medicine PERSPECTIVES

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Tug-of-War over Abortion in Texas

Matthew Chayt

“The application to vacate stay of final judgment pending appeal presented to Justice Scalia and by him referred to the court is granted in part and denied in part.”

With that deceptively mundane sentence in an October 2014 order, the Supreme Court began yet another foray into one of the most controversial of all health law topics: abortion. But to understand the order’s significance, it is necessary to first examine the Texas legislation and federal court decisions that precipitated it.

In August 2014, U.S. District Judge Lee Yeakel, a George W. Bush appointee, heard *Whole Woman’s Health, et al. v. Lakey, Commissioner, Texas Department of Health Services, et al.* in Austin. The plaintiffs, a group of Texas abortion clinics, argued that two provisions of a new state abortion statute, known as HB 2, would, as applied to them, impose an “undue burden” (a key phrase from landmark Supreme Court abortion case *Planned Parenthood v. Casey*) on women seeking abortions by requiring: (1) that all abortion clinics in the state comply with standards for ambulatory surgical centers, and (2) that all physicians performing an abortion possess active admitting privileges at a hospital no further than 30 miles away. Judge Yeakel agreed with the plaintiff clinics and granted a preliminary injunction blocking enforcement of HB 2.

On appeal, however, the Fifth Circuit took a different view. In *Whole Woman’s Health v. Lakey*, 2014 U.S. App. LEXIS 18896 (2014), the Fifth Circuit held 2-1 that HB 2 advanced a legitimate interest in protecting women’s health, and with one limited exception, reversed Judge Yeakel’s stays. The Fifth Circuit first expressed confusion about the reach of Judge

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Two-Track Peer Review a New Reality in California

Kurt Melchior

Editor’s Note: California’s Fahlen decision is likely to be a true game-changer for all ACLM members who practice in the peer review arena, including those who practice in other jurisdictions. If your jurisdiction has not adopted the Fahlen exception to the exhaustion doctrine, the playing field is now set for similar challenges or for new legislation akin to the California whistleblower statute at issue. While arguably a victory for individual physicians, this new paradigm shift, as the author describes, will undoubtedly and substantially increase

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Yeakel's judgment, noting that it could be interpreted to apply in multiple ways. The Fifth Circuit then explained that its own ruling would clarify the issues in dispute.

Appellate courts like the Fifth Circuit generally only contradict the factual findings of lower courts in the case of clear error. Indeed, the Fifth Circuit accepted the district court's findings that HB 2 would lead to an 80 percent reduction of abortion clinics in Texas, with a 100 percent reduction in clinics west and south of San Antonio.

The Fifth Circuit likewise acknowledged Judge Yeakel's findings that the costs to abortion clinics of complying with HB 2 would be millions of dollars, and that HB 2 would increase the travel distance to an abortion clinic for many Texan women—for example, over a million Texan women would live more than 150 miles from a clinic. As discussed below, the Fifth Circuit may have accepted these factual findings, but it analyzed them very differently.

In order to decide whether to preliminarily enjoin enforcement of HB 2, whether against a handful of clinics or all of Texas, the central issue for the Fifth Circuit to resolve was whether Texas had shown a likelihood of success in refuting the clinics' claims that the ambulatory surgical center provision was unconstitutional on its face—in other words, unconstitutional as a matter of law, regardless of its effects on particular clinics. As the opinion by Judge Jennifer Elrod, another George W. Bush appointee, explained, Texas had indeed shown it was likely to succeed against the clinics.

First, the Fifth Circuit reasoned, HB 2 met the low standard of rational basis review—the requirement that a law be rationally related to a legitimate government interest. (No party disputed Judge Yeakel's conclusion on this point.)

Next, under the Fifth Circuit's own test for analyzing a law's compliance with *Planned Parenthood v. Casey*, the court had to determine whether HB 2 had either the **purpose** or **effect** of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. According to the Fifth Circuit, Judge Yeakel had misunderstood or misapplied that test in concluding that HB 2 aimed to treat abortion facilities in a disparate and arbitrary manner. In fact, according to Texas's lawyers, HB 2 does not treat non-abortion ambulatory surgical centers any differently.

The statute's grandfathering provisions for facilities previously

licensed as ambulatory surgical centers that failed to comply with new building code requirements, for example, applies equally to abortion facilities and other ambulatory surgery centers. But more importantly, the Fifth Circuit found that Judge Yeakel had cited no evidence showing that HB 2 had been enacted for the purpose of imposing an undue burden on women seeking abortions, or any other improper purpose. The Texas legislature had stated that the goal of HB 2 was to increase the health and safety of abortion patients and provide them with high quality health care.

In a particularly intricate analysis, the Fifth Circuit also determined that HB 2 would not have the **effect** of imposing an unconstitutional burden on women seeking abortions. According to the relevant Supreme Court precedent, an abortion-regulating statute would be unconstitutional if, in “a large fraction” of cases, it would present “a substantial obstacle to a woman's choice to undergo an abortion.” The district court had argued that because HB 2 would be tantamount to a complete ban on abortion for a “significant number” of Texas women, it was unconstitutional, but the Fifth Circuit disagreed, because under the Supreme Court's *Carhart* case, and the Fifth Circuit's own precedent as to abortion, the standard to be met was actually whether the statute would affect a “large fraction” of women.

The Fifth Circuit also faulted Judge Yeakel's apparent substitution of his own judgment—in this case, that Texas abortion clinics are already safe for women—for that of the Texas legislature. “In our circuit,” the Fifth Circuit stated, “we do not balance the wisdom or effectiveness of a law against the burdens the law imposes.”

The Fifth Circuit's own analysis of the “effect” issue carefully scrutinized the plaintiffs' showing that the ambulatory surgical center provision would increase driving distances to clinics. The plaintiffs' expert opined that HB 2 would cause 900,000 out of approximately 5.4 million women of reproductive age in Texas to drive at least 150 miles to the nearest abortion clinic. Given that this fraction is only approximately one-sixth, the Fifth Circuit argued that the number of women affected is “nowhere near a ‘large fraction.’”

The Fifth Circuit rejected the plaintiffs' calculations as contrary to Supreme Court precedent and governed by “merely a tautology” that would always result in a large fraction of women

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the cost and complexity of peer review proceedings, the extent to which we will only realize after many years of testing the issues raised in the article.

Few recent cases seem to presage greater changes in the relations between medical staffs and peer groups on the one hand and outlier practitioners on the other hand, than the California Supreme Court's decision early in 2014 in *Fahlen v. Sutter Central Valley Hospitals*, 58 Cal. 4th 655 (2014). While *Fahlen* lays out some broad ground rules (or more accurately, confirms that the California Legislature has laid out these new ground rules), to date no later cases have filled out *Fahlen's* broad open areas. A writer can only identify these places where, since *Fahlen*, broad disputes are likely to occupy physicians and other health care organizations, their lawyers and the courts.

Before *Fahlen*, under the exhaustion doctrine, medical staffs and other peer groups could impose discipline on their outlier members, secure in the knowledge that their internal disciplinary proceedings would be held in confidence and that disciplined members had limited options for review, with retribution claims most likely barred by the finality of the disciplinary decision. But in the *Fahlen* case, a dissident physician facing discipline sued the hospital claiming that it brought the action against him in retaliation for his complaints about alleged substandard nursing performance.

The Supreme Court of California held that the whistleblower statute at issue had been amended in 2007 so as to expressly permit a physician facing hospital discipline to bring a separate suit in the Superior Court, alleging that the discipline – threatened, pending or actually imposed – had been brought in retaliation for his whistleblowing activities, and gave him the right to seek damages for such conduct.

That new statute conflicted with existing law, which requires that a health care worker subject to institutional discipline could not challenge such disciplinary action until the peer review disciplinary process had been completed, including appellate review, at which point the discipline became clothed with many hallmarks of finality, thus precluding further challenge. But in *Fahlen*, the California Supreme Court ruled unanimously that the Legislature understood the changes it made in this system and that the conflicts it had thus created between the right of a medical staff or similar organization to discipline a member through the administrative process on the one hand, and the

right of a dissident physician to challenge such discipline as retaliation for his whistleblowing on the other, had to exist side by side.

That ruling creates a new landscape for hospitals, medical staffs and other peer review bodies. The Court mentioned some problems which this new playing field created, but left all of them for resolution on another day. No appellate decisions since *Fahlen* was published in February 2014 have addressed those problems, some of which are:

- The Supreme Court held that the whistleblower statute “forbid[s] a health care facility to retaliate or discriminate ‘in any manner’” against a staff member because of whistleblowing activity and entitles the worker to prove such violation and obtain “appropriate relief, in a civil suit before a judicial fact finder.”
- In his civil suit, the self-designated whistleblower may allege that his whistleblowing was “a reason” – not necessarily **the** reason or even the main reason – for the disciplinary sanction. The trier of fact, presumably a jury, will decide whether that claim is true, and the whistleblower may then get his “appropriate relief” there: presumably damages, and perhaps an injunction against having the discipline carried out. This last point – about a possible injunction – has not been the subject of any discussion of which we are aware.
- Both the federal and the state statutes that created the disciplinary process contain immunity clauses which insulate the participants from damage claims; but both statutes require that the peer reviewers have acted fairly. The federal statute, 42 U.S.C. §11111(a), establishes immunity if the actors acted in the “reasonable belief that the action was in the furtherance of quality health care” and “in the reasonable belief that the action was warranted by the facts known ...” The state statute applies if the challenged actions were taken “without malice.” (Cal. Civ. C. §43.7.) Who decides whether these immunities apply: the fact finder, i.e., the jury, in the whistleblower case?
- The California statute establishes a presumption of retaliatory motive which applies if “the discriminatory action occurs within 120 days of the filing of the grievance or complaint by the employee, member of the medical staff

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- or any other health care worker of the facility” (section 1278.5(d)(1)). Does “within 120 days” mean within 120 days before or after the grievance was filed, or either one? Does this provision invite nonconforming physicians to file grievances beforehand, and to renew them every 120 days, in order to have ammunition against feared disciplinary proceedings? Are those grievances likely to multiply, even if only as defenses against anticipated disciplinary proceedings?
- The statute defines this presumption of retaliatory motive as “a presumption affecting the burden of producing evidence as provided in section 603” of California’s Evidence Code. Section 603, unlike other parts of the Evidence Code, defines a presumption which disappears upon the introduction of *any* contrary evidence. Thus, curiously, this presumption is likely to have little or no practical effect because presumably all those accused of discriminatory conduct in the peer review proceedings will come forward to testify that they acted in good faith. So why did the Legislature insert this nearly meaningless “presumption?”
 - It is unclear from the *Fahlen* opinion, but strongly hinted there, that the finality of a peer review discipline within its own terms will not bar a separate claim of discriminatory prosecution. It thus seems theoretically possible that a controversial physician may at the same time be disciplined – even to the extent of losing her privileges to practice at the institution entirely – and yet have the right to ask a jury for damages for that very same conduct although differently labeled and put forward. It also appears that the two sets of proceedings may proceed concurrently on their separate tracks.
 - The whistleblower statute prohibits discovery of peer review proceedings, but only as long as the hearing part of those proceedings is ongoing. But peer review proceedings continue well beyond the hearing process, involving deliberations, decisions, internal appeals, and then challenges in court. Further, there are statutes that make peer review proceedings confidential as against third-party efforts to penetrate them, including the respondent if he were to try. Yet, members of the peer review panels are allowed to bring the facts of such proceedings forward. Under the *Fahlen* regime there are sure to be disputes of many varieties about the production of peer review proceeding evidence, which had heretofore been almost completely sealed off.
 - SLAPP motions (special motions to strike complaints as impermissibly brought to challenge the defendant’s constitutional rights of free speech) are a common feature of the litigation landscape. They may be expected to blossom in this environment where free speech, whistleblowing or otherwise, is very close to the surface. Where there are enough facts to get the plaintiff past summary judgment, i.e., where the claims of retaliation are not made entirely without a factual basis, SLAPP motions will not likely succeed. But they stop the litigation in its tracks, are subject to appeal, allow recovery of attorneys’ fees if successful, and may generally be expected in matters of this nature, even if only as a tool for short term litigation strategy.
- These are some of the more immediate concerns raised by *Fahlen*. This is not an instance of the courts “making new law.” The California Supreme Court was very careful to point out that it was only interpreting a statute. It is the California Legislature that recognized the collision between two important public policies – that of removing incompetent and disturbing practitioners from their professional environment if needed, and the right of whistleblowers to be protected against retaliation – and which placed both policies in the public arena to compete with each other, perhaps to the end of bringing inconsistent results. ■

Privacy and the Physician-Patient Relationship: Redact the Records even if Burdensome

Marshall Rinderer

In *Snibbe v. Superior Court*, 168 Cal.Rptr.3d 548 (Cal. Ct. App. 2nd Dist. 2014), the Second District of the Court of Appeals in California considered whether Dr. Jason C. Snibbe, an orthopedic surgeon, must produce 160 postoperative orders in the suit for wrongful death of Mildred Gilbert as ordered by the trial court. The Court of Appeals limited discovery to pain management and denied the physician's argument that the order violated physician-patient relationship.

Ms. Gilbert's two sons filed this wrongful death claim after their mother died shortly after a hip replacement procedure performed by Dr. Snibbe. The postoperative orders included instructions to receive pain medication, including morphine, hydromorphone and others. The orders specified a "maximum dose of two milligrams of hydromorphone every two hours for severe pain."

Ms. Gilbert passed away several hours after a nurse gave her a two milligram IV dose of hydromorphone, a schedule II controlled substance, which has a high risk of fatal respiratory depression according to Gilbert's expert. The expert also opined that the ordered dosage did not follow the proper standard of care and was a substantial factor in the death of Ms. Gilbert.

Dr. Snibbe stated that his physician assistant, Jennifer Cabrera, prepared the postoperative orders. Dr. Snibbe may authorize the orders if the physician assistant complies with California's Business and Professions Code Section 3502.1. Yet, because hydromorphone is a schedule II controlled substance, the "supervising physician must review, countersign, and date the patient record within seven days." It was unclear if Snibbe fully complied with that requirement.

During Dr. Snibbe's deposition, it became clear that an anesthesiologist was not consulted because the anesthesiologist stated he would not have recommended the dosage. Gilbert's expert showed the delegation of services agreement between Snibbe and his physician assistant did not include writing postoperative orders. Similarly, the expert opined that the physician assistant was not qualified to decide Ms. Gilbert's postoperative orders.

Because Snibbe asserted that he routinely gave drug orders to Cabrera, who wrote them and saw that they were carried out,

Gilbert sought in discovery all postoperative orders for opiates, including hydromorphone, and including all of Snibbe's and Cabrera's signed postoperative orders during all relevant times. The court rejected Dr. Snibbe's arguments that "the discovery order violates the physician-patient privilege and third party privacy rights, seeks production of irrelevant evidence, and is unduly burdensome" and granted the motion to compel but "limited the scope of discovery to 160 postoperative orders including provisions for the administration of opioids, split equally between surgeries [Snibbe] performed at Cedars before and after Mrs. Gilbert's surgery."

The appellate court rejected the surgeon's argument that the evidence was entirely irrelevant and opined that Dr. Snibbe made them relevant when he claimed that his common practice, *i.e.*, his habit or custom, was to dictate them to the assistant, and thus that his practice was indeed evidence that he was not negligent in this particular case. The orders sought could potentially confirm or deny whether his custom and practice was, in fact, what he claimed it to be, or whether the assistant entered boilerplate orders on her own account.

The Court concluded that the evidence of past postoperative orders was relevant and opined "[i]f all or substantially all postoperative orders include substantially similar provisions for opioids, the orders would tend to show that those provisions were indeed 'boilerplate,' rather than patient satisfaction."

The next issue was whether the physician-patient privilege protected Dr. Snibbe from disclosing the postoperative orders. As to the privilege, the court relied on *Rudnick v. Superior Court*, 11 Cal. 3d 924 (1974)—a case permitting the production of adverse drug reaction reports over a drug company's objection based on physician-patient privilege, when personally identifying information was redacted from the reports. Noting a split in authority among several states, the Court declined to impose a "blanket prohibition against disclosure of redacted patient medical records[,] as inconsistent with the California Supreme Court's reasoning.

The Court thus held that under *Rudnick*, the drug orders, redacted of any personally identifying information, are not

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privileged because they do not reveal any diagnosis made regarding any particular patient. Notably, nothing about the orders provides any significant opportunity for reverse engineering of patient identity—an issue that has come up in later court of appeal cases that distinguish *Rudnick*. See, e.g., *Binder v. Superior Court*, 196 Cal. App. 3d 893, 899 (1987) (declining to follow *Rudnick* when the discovery sought were patient photographs).

Even though some states may prohibit disclosure even after a redaction, the Court concluded that “[t]he physician-patient privilege does not prevent the disclosure of portions of redacted postoperative orders in the case.” The Court felt the remoteness of possible identification outweighed the policy of protecting a patient’s identity and potential embarrassment of the public being made aware of ailments. So the privilege was not implicated.

Also considered was whether the trial court failed to balance third-party privacy against the Gilberts’ need in discovery. The Court reached a similar result on Snibbe’s argument that production would violate the privacy rights of the surgeon’s other patients. Before a court is required to engage in the balancing of privacy interests against the needs of discovery, the Court explained, a party resisting discovery must first make a threshold showing of a potentially serious intrusion into someone’s private information.

Relying on the Supreme Court’s recent decision in *Sander v. State Bar of California*, 58 Cal. 4th 300 (2013)—a case that ordered the production of demographic and education data concerning state bar takers, redacted of identifying information—the Court held that no serious invasion of patient privacy occurs when a party produces medical records entirely

redacted of identifying information or data.

The Court lastly considered whether the discovery order of 160 postoperative orders was overly burdensome, which an appellate court will review under the abuse of discretion standard. Dr. Snibbe argued the discovery order was burdensome because “he needs to expend valuable time identifying, reviewing, and redacting those orders” and because he could not access the records except for legitimate medical reasons. If Dr. Snibbe accessed the records for non-legitimate medical reasons, he argued, then he would be subject to penalties under both California’s Confidentiality of Medical Information Act (CMIA) and the federal government’s Health Insurance Portability and Accountability Act of 1996 (HIPAA).

However, both of those statutes allow medical records to be produced with a court order and the production of redacted postoperative orders would not violate either statute, and the court concluded that Dr. Snibbe had not shown the trial court abused their discretion.

In conclusion, the Court granted in part, and denied in part, the petition for writ of mandate. The trial court was to set aside the order and to issue a new order “requiring production of the pain management provisions of the 160 postoperative orders.” The Court stressed the importance of redacting personal information. The petition was denied for the rest of Dr. Snibbe’s request. Justice Willhite and Justice Manella concurred with the majority. ■



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Seventh Circuit Rejects Challenge to the Affordable Care Act

Gretchen Leach

In *Ass'n of Am. Physicians & Surgeons, Inc. v. Koskinen*, 768 F.3d 640 (7th Cir. 2014), the Seventh Circuit ruled that the plaintiffs—an association of physicians and surgeons and one member physician—lacked standing to seek declaratory and injunctive relief against the implementation of the Affordable Care Act (“ACA”). More specifically, the plaintiffs were attempting to challenge the IRS’s decision to implement the ACA’s employer mandate to provide health insurance later than the individual mandate, as well as the IRS’s attempt to increase the insurance premiums of some of the plaintiff organization’s members. The plaintiffs brought their claim against John Koskinen in his official capacity as Commissioner of the Internal Revenue Services (“IRS”).

This case follows a district court decision in which the plaintiffs argued they were entitled to conduct discovery and gather data on the implementation of the ACA before the court required them to show standing. The plaintiffs then asked the district court to enjoin the IRS in committing what they alleged to be a violation of the separation of powers doctrine and the Tenth Amendment. The plaintiffs maintained that the delayed implementation of the employer mandate under the ACA would cause “irreparable harm” because the plaintiffs’ members have medical practices that depend on patients’ direct (or “cash”) payments for care rather than on payments by insurance companies or other third-party payers. *Ass'n of Am. Physicians & Surgeons, Inc. v. Koskinen*, No. 13-C-1214, 2014 WL 1056495, at *3 (E.D. Wis. Mar. 18, 2014) *aff'd sub nom. Ass'n of Am. Physicians & Surgeons, Inc. v. Koskinen*, 768 F.3d 640 (7th Cir. 2014.).

One member claimed that approximately 50% of his patients paid directly, or “out-of-pocket,” for his services. The plaintiffs alleged that they would lose patients and revenue because: (1) the defendant’s decision to delay implementation of the Employer Mandate would cause large employers to not offer ACA-compliant health insurance for 2014 to their full-time employees; (2) employees would have to pay out-of-pocket for insurance plans from which the plaintiffs either would not or could not accept payment; (3) the employees would be left with less discretionary income; and (4) the employees would purchase fewer services from plaintiffs’ members.

The IRS moved to dismiss the action for lack of subject matter jurisdiction because the plaintiffs lacked standing to sue.

The IRS argued that the plaintiffs’ complaint contained only speculative predictions and that such complaints are “routinely dismissed without any discovery.” *Id.*

The district court noted that the plaintiffs faced a high burden to show standing because: (1) the plaintiffs themselves were not the object of the action that they challenged; and (2) the plaintiffs sought to challenge the government’s decision to tax or not tax a third party. *Id. at 5.* The district court also noted that such plaintiffs usually lack standing to litigate the tax obligations of others because such suits are generalized grievances that “operate to disturb the whole revenue system of the government,” explaining further that the “general rule that a party may not litigate about strangers’ taxes is well-established.” *Id.*

The district court dismissed the plaintiffs’ claims for lack of standing because “each link” of the plaintiffs’ “lengthy causal chain” to show irreparable harm was “speculative and [failed] to support Plaintiffs’ standing argument.” *Id. at 6.* In addition, the causal chain “relies on a series of discretionary acts by third parties.” The court called each link of Plaintiffs’ causal chain “tenuous,” and noted that it failed to establish an injury that is imminent or certainly impending. In addition, Plaintiffs failed to show that any future injury would be fairly traceable to the IRS.

In affirming the decision on September 19, 2014, the Seventh Circuit reiterated the district court’s view that “[t]he [Supreme] Court has rejected efforts by one person to litigate about the amount of someone else’s taxes (or someone else’s subsidies, which are taxes in reverse.)” *Ass'n of Am. Physicians & Surgeons, Inc. v. Koskinen*, 768 F.3d 640, 642 (7th Cir. 2014). The Court cited to previous Supreme Court cases such as *Allen v. Wright*, 468 U.S. 737 (1984), in which parents with children who attended public schools challenged the IRS’s approach to tax exemptions for private schools, claiming that allowing schools engaged in racial discrimination to obtain tax exemptions affected the composition of public schools. The Court determined that the effect was too remote to establish standing because it depended on reactions of many intermediate actors and that “[t]he longer the causal chain, the less appropriate it is to entertain standing.” *Id. at 642.*

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Patient Safety and Quality Improvement Act Does not Protect Nurse's Incident Report from Discovery

Shannon Fruth

The Supreme Court of Kentucky, in *Tibbs v. Bunnell*, 2012-SC-000603-MR, 2014 WL 4115912 (Ky. Aug. 21, 2014), reversed a decision issued by the state's Court of Appeals regarding the disclosure of a surgical nurse's post-incident event report. The incident report was requested as part of a medical malpractice and wrongful death lawsuit filed by the estate of a deceased patient. In so doing, the Court held that the Patient Safety and Quality Improvement Act (PSQIA) does not supplant state mandated medical reporting regulations, and such information, even if contained within a patient safety evaluation system pursuant to the Act, is discoverable by adverse parties in litigation.

A federal statute, the PSQIA established a system of patient safety organizations and a national patient safety database. To encourage reporting and broad discussion of adverse events, near misses, and dangerous conditions, it also established privilege and confidentiality protections for Patient Safety Work Product (as defined in the act).

In the underlying medical malpractice case, the deceased died as a result of complications from an elective spine surgery performed at the University of Kentucky Hospital. *Tibbs v. Bunnell*, 2012-SC-000603-MR, 2014 WL 4115912, at *1, (Ky. Aug. 21, 2014). This appeal stems from a discovery dispute between the parties regarding a post-incident report generated by a hospital surgical nurse concerning the performed surgery. The report in question was created using the hospital's patient safety evaluation system, which is "an information collection and management system implemented at the hospital pursuant to the Patient Safety Act." *Id.* at *11.

During discovery, the decedent's estate requested the report in question documenting the surgery, and Tibbs moved for a protective order of discovery preventing its disclosure. Tibbs asserted that this report was protected from discovery because it was privileged under the PSQIA. The trial court denied the motion and ordered production of the document if it was generated by someone with actual knowledge of medical care.

Tibbs sought a writ of prohibition from the Court of Appeals to prevent the trial court from ordering production of this report.

The Court of Appeals granted the writ of prohibition, holding that the PSQIA's federal privilege preempted the trial court from ordering disclosure under federal statutory law. The Court of Appeals limited the Act's privilege to "documents that contain[ed] a self-examining analysis" and remanded the issue to the trial court to view the document *in camera* to determine if this report contained "self-examining analysis." Tibbs appealed from the Court of Appeals decision, citing an erroneous limitation of the privilege to documents that contain "self-examining analysis" because this term was neither found nor implied in the PSQIA itself, or the Act's legislative history.

Justice Scott, writing for the majority, first lays the framework for the Supreme Court of Kentucky's legal analysis, discussing both the history and purpose of the PSQIA. Of particular importance is a House of Representatives Report that recognized that the purpose of the Act was to "encourage the reporting and analysis of medical errors and health care systems by providing peer review protection of information reported to patient safety organizations for the purposes of quality improvement and patient safety." *Id.* at *3. As such, some communications that are deemed to be Patient Safety Work Product become privileged under the Act and cannot be disclosed for litigation or other purposes.

The narrow issue raised, as the majority frames it, is "whether the Court of Appeals erred in limiting the privilege to documents employing a "self-examining analysis" rather than the statutory language used in the Act." *Id.* The Supreme Court of Kentucky agrees with Tibbs that the Court of Appeals inappropriately relied on *Francis v. United States*, No. 09 Civ. 4004(GBD) (KNF), 2011 WL 2224509 (S.D.N.Y. May 31, 2011), in its definition of Patient Safety Work Product, because that Court relied upon a report which accompanied a version of the Act that was never enacted.

The Supreme Court of Kentucky instead focuses its attention on the statutory definition of Patient Safety Work Product, and the exceptions that are explicitly created within the statute.

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U.S. Supreme Court Will Hear Idaho's Medicaid Challenge in 2015

Gretchen Leach

On October 2, 2014, the Supreme Court of the United States granted a petition for writ of certiorari to determine whether the Supremacy Clause grants a private right of action to Medicaid providers to enforce the Medicaid Act against Idaho, a state where Congress chose not to create enforceable rights under the Act. *Armstrong v. Exceptional Child Ctr., Inc.*, No. 14-15, 2014 WL 3107841, at *1 (U.S. Oct. 2, 2014).) The Supreme Court will decide whether to uphold the Ninth Circuit's affirmation of a lower court's summary judgment ruling in favor of a group of providers that brought suit against the directors of state agencies in Idaho, finding that the providers could bring a private action to enforce the Medicaid Act pursuant to the Supremacy Clause. The Ninth Circuit specifically found that the providers of certain living services for Medicaid-eligible individuals could challenge the failure of the state agencies' directors to adopt rates that bore a reasonable relationship to their costs of service based on cost studies. The state agencies' directors had admitted that the current rates did not substantially reimburse the providers for costs and that the new rates were not adopted based on pure budgetary reasons.

In the district court decision from December 2011, five Idaho corporations challenged the state's decision not to amend existing Medicaid reimbursement rates. (*Inclusion, Inc. v. Armstrong*, 835 F. Supp. 2d 960 (D. Idaho 2011) *aff'd sub nom. Exceptional Child Ctr., Inc. v. Armstrong*, 567 F. App'x 496 (9th Cir. 2014).) The plaintiffs provided "residential habilitation services" to Medicaid patients. Medicaid is "a cooperative federal-state program that directs federal funding to participating states to provide medical assistance" to needy individuals. If a state wants to participate in the program it must follow the requirements of the federal Medicaid Act, which requires states to develop a "state plan." *Id. at 962*. The federal Centers for Medicaid and Medicare Services ("CMS") must approve that plan. The CMS may waive certain Medicaid Act requirements if a state can show that the cost of caring for an individual in a home or community based program would be less than or equal to the cost of institutional care for the same individual. The CMS approved Idaho's use of three such waiver programs; the services that the plaintiffs provided were pursuant to Idaho's waiver.

Idaho law requires the Idaho Department of Health and Welfare ("IDHW") to "implement a methodology for reviewing and determining reimbursement rates" so that Medicaid rates

would take providers' actual costs of providing services into consideration. *Id.* IDHW retained a third party firm to study these costs. Based on its findings, the firm recommended rate increases to the state legislature in 2006. Nonetheless, the legislature declined to raise its rates until the U.S. District Court rendered its opinion on the subject in December 2011. The reason for the state's inaction was that the legislature did not "appropriate the necessary funds." *Id.* The parties stipulated to all relevant facts and filed cross motions for summary judgment.

Section 30A of the Medicaid Act provides that a state that receives Medicaid funds must set forth a process for the use and payment of Medicaid services in its state plan. (42 U.S.C. 1396a(a)(30)(A).) In *Inclusion, Inc. v. Armstrong*, 835 F. Supp. 2d 960, 963 (D. Idaho 2011) *aff'd sub nom. Exceptional Child Ctr., Inc. v. Armstrong*, 567 F. App'x 496 (9th Cir. 2014), the Court ruled that a state agency must consider actual provider costs to fulfill this requirement: "[t]o satisfy [section] 30A's procedural requirements, the IDHW cannot set rates based on responsible cost studies, then disregard undisputed evidence of increasing costs from studies completed in subsequent years." *Id. at 964*. The court granted the plaintiffs' motion for summary judgment, finding that section 30A of the Medicaid Act "includes procedural requirements to achieve economy, efficiency, access, and quality." *Id. at 964*. Because section 30A has both substantive and procedural requirements, a state must have a justification other than simply budgetary reasons when its reimbursement rates do not substantially reimburse providers for their actual costs.

In its decision, the district court noted that the Ninth Circuit "stands alone" in finding that section 30A contains procedural requirements. Unsurprisingly, the Ninth Circuit affirmed the district court's decision, noting that the plaintiffs had a private right of action under the Supremacy Clause.

Idaho's writ of certiorari presented the case in two questions:

1. Does the Supremacy Clause give Medicaid providers a private right of action to enforce § 1396a(a)(30)(A) against a state where Congress chose not to create enforceable rights under that statute?

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Patient Safety and Quality Improvement Act Does not Protect Nurse's Incident Report from Discovery

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The definition of Patient Safety Work Product is quite broad and includes any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material), which could improve patient safety, health care quality, or health care outcomes, that are assembled or developed by a provider for reporting to a Patient Safety Organization (PSO) and are reported to a PSO.

Patient Safety Work Product, however, does not include “a patient’s medical record, billing and discharge information, or any other original patient or provider record,” and as such are thus not protected as privileged under the Act. Additionally, Kentucky Administration Regulations require the creation of reports to guide hospitals, which include incident investigation reports. Because these reports are required in the general course of business, the reports are held to be discoverable in litigation. The court suggests, with guidance and interpretation from the United States Department of Health and Human Services, that state regulations are not to be supplanted by the Act.

The information contained in the medical report at issue, although relevant to the PSQIA and created within a patient safety evaluation system, cannot be considered to be patient safety work product because “its collection, creation, maintenance, and utilization is mandated by the Commonwealth of Kentucky as part of its regulatory oversight of its healthcare facilities.” The Court opines that Congress did not intend to deprive states of the right to create and enforce regulations that mandate disclosure of medical information and circumvent their disclosure by mere placement in a patient safety evaluation system. The Court concludes that “information normally contained in an incident report is not

privileged under the Act and may be discovered, following an *in camera* review, and its information is compelled,” and may be appropriately separated if privileged material is commingled with non-privileged material.

Justice Abramson, joined by Chief Justice Minton, dissented from the majority’s holding, and argued that the majority’s holding undercuts the purpose and effectiveness of the PSQIA. Further, they believed this ruling would discourage open communication among medical providers who are cognizant of liability. Focused on the purpose of the PSQIA, Abramson stressed that “success of the system is contingent upon the willingness of providers to supply safety-related information” to Patient Safety Organizations, and that such participation will not result in disclosure in tort or peer-review systems. While Justice Abramson and Minton agree with the majority that the PSQIA was not intended to supplant state regulations, information recorded for submission to a Patient Safety Organization should be considered to be privileged as patient safety work product under the Act given its broad purpose and Congressional intent.

State law still governs access “to records and reports existing outside the patient safety evaluation system and state law may entitle an interested party to demand that a required record or report be generated.” *Id.* at *15. The privilege under the PSQIA, however, “assures participation in the patient system,” and that such participation “will not subject them to adverse consequences.” *Id.* Because the majority’s holding allows the invasion of a hospital’s safety evaluation system, Justice Abramson and Minton conclude that disclosure of the medical report would violate the PSQIA. ■

U.S. Supreme Court Will Hear Idaho's Medicaid Challenge in 2015

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2. If Medicaid providers have a private right of action, are a state’s Medicaid provider reimbursement rates preempted by § 1396a(a)(30)(A) where they do not bear a reasonable relationship to provider costs and remain in place for budgetary reasons?

(*Armstrong v. Exceptional Child Center, Inc.*, 2014 WL 3101423 (U.S.)). Twenty-eight states filed *amicus curiae* briefs in support of Idaho, claiming that the Ninth Circuit’s interpretation of the Supremacy Clause prevents Congress from hindering

the private enforcement of federal statutes and treaties against state officials. The states claimed that this case presented an ideal opportunity to consider the implied-right-of-action issue. In a 5-4 decision in 2012 the Court declined to address the Supremacy Clause in *Douglas v Independent Living Center*, leaving questions as to the right to bring such a claim, although Chief Justice Roberts indicated in the dissent that he would have held that the Supremacy Clause did not offer a right of action on its own if Congress had not explicitly created one. ■

Tug-of-War over Abortion in Texas

continued from page 2

being affected. The court also questioned the plaintiffs' claims that the clinics left operating would be unable to handle the increased caseload caused by HB 2. The Fifth Circuit observed that "[t]he fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it."

Finally, the Fifth Circuit reviewed the district court's judgment on the ambulatory surgical center requirement as applied to a Reproductive Services abortion clinic in El Paso. The Fifth Circuit was bound by its own precedent not to consider that women in El Paso may also travel to nearby Santa Teresa, New Mexico, to obtain an abortion. Instead, the Fifth Circuit was obligated to focus on clinics within Texas. Because El Paso is remotely located from other Texas clinics, the Fifth Circuit carved out a small exception to its otherwise sweeping victory for proponents of HB 2. The Fifth Circuit ruled that the El Paso clinic would not have to meet the physical plant requirements of HB 2's requirement that all abortion clinics meet standards for ambulatory surgical centers—but that the operational requirements would still apply.

Perhaps especially with a hot-button topic such as abortion, there is always the potential for dramatic and abrupt reversals in litigation, and the *Whole Woman's Health* case did not disappoint in that regard. Days after the Fifth Circuit's ruling, the plaintiffs appealed to Justice Scalia—the Supreme Court

justice assigned to the Fifth Circuit—for an emergency stay of the Fifth Circuit's judgment. Justice Scalia referred the matter to the Supreme Court as a whole, and over Justices Scalia, Thomas and Alito's disagreement, the Court vacated the Fifth Circuit's stay order enjoining the admitting privileges requirement as applied to the McAllen and El Paso clinics, as well as the stay order directed at HB 2's ambulatory surgical center requirements.

The Supreme Court's decision to reinstate much of Judge Yeakel's ruling surprised some, because the Supreme Court had refused to take action in a 2013 case challenging HB 2. With some Texas abortion clinics re-opening, the Fifth Circuit ordered the plaintiff clinics and the Texas legal team to file briefs by December 8, 2014, for an upcoming hearing on the merits of the case.

The New York Times Editorial Board hailed the Supreme Court's action to keep the clinics open, adding that it "does not necessarily foretell how the court would rule on the merits." Meanwhile, Texas Attorney General—and gubernatorial candidate—Greg Abbott has argued that the closure of clinics by HB 2 is a "manageable inconvenience." The constitutional battle over abortion may be an ongoing judicial tug-of-war, but whenever it intercedes either for or against a woman's right to choose, the Supreme Court has the strongest pull every time. ■

Seventh Circuit Rejects Challenge to the Affordable Care Act

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The plaintiffs attempted to distinguish *Allen* because it rose from the Equal Protection Clause, while the plaintiffs' claim rests on the Tenth Amendment and the separation of powers doctrine. The Seventh Circuit noted that such a distinction was irrelevant to standing.

Plaintiffs also relied on *Bond v. United States*, 131 S.Ct. 2355 (2011), which holds that a private person may present arguments based on the Tenth Amendment and the Commerce Clause. However, the Seventh Circuit noted that "*Bond* does not hold that *everyone* is entitled to litigate about the division between state and federal authority. The Supreme Court does

not think that the Constitution's structural features are open to litigation by persons who do not suffer particularized injuries." *Id.*

The Seventh Circuit concluded its decision by leaving the door open to a future plaintiff who would be "a much more appropriate champion of the contention that the IRS has not done what it should to accomplish the statute's goal of universal coverage." In its view, the only persons who would have "a plausible claim to relief" would be those "seeking to advance the interests protected by the mandatory-insurance portions" of the ACA. ■

Creditor Calls to a Patient Unsuccessfully Challenged in Florida

Matthew Chayt

When a patient is admitted to the hospital, does his wife's provision of his cell phone number make that information fair game for use by creditors? In September 2014, the Eleventh Circuit answered that question "yes" in rejecting an action by a potential class action plaintiff.

The *Mais v. Gulf Coast Collection Bureau* case began in 2009 with Mark Mais' trip to the Westside Regional Medical Center ER in Plantation, Florida, near Fort Lauderdale. Mais' wife worked with the hospital's staff to complete Mais' paperwork, and she provided Mais' cell phone number to the admissions representative, although the number was identified as a residential line.

Mais' wife also acknowledged the hospital's Notice of Privacy Practices (NPP) (required for HIPAA compliance) and agreed that "the hospital and the physicians or other health professionals involved in [Mais'] care [may] release [his] healthcare information for purposes of treatment, payment or health care operations," including to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment." During his stay in the hospital, Mais incurred a medical debt to Florida United Radiology totaling just under \$50.00. Florida United Radiology used McKesson as their biller, which duly sent Mais a bill for the amount.

Mais did not pay McKesson's bill, however, and pursuant to an agreement with Florida United Radiology's parent (Sheridan Acquisition), Gulf Coast Collection Bureau assumed responsibility for collecting the \$50.00. Subsequently, Mais received between 15 and 30 automated phone calls from Gulf Coast Collection Bureau to his cell phone about the debt, including four voicemails. The Telephone Consumer Protection Act (TCPA) prohibits making any non-emergency call to a cellular telephone number using an automatic telephone dialing system or artificial prerecorded voice unless the recipient of the call has given "prior express consent."

Mais sued Florida United Radiology, Sheridan Acquisition, and Gulf Coast Collection Bureau on behalf of himself and a potential class of others he alleged had received similarly prohibited calls. In federal district court in Miami, Judge Robert Scola ruled that Mais could not maintain his action against Florida United Radiology and Sheridan Acquisition

because they did not actually make the prohibited calls, the only activity prohibited by the TCPA. But Judge Scola granted summary judgment to Mais on his suit against Gulf Coast Collection Bureau, on the basis that the collection agency had clearly violated the statute and that a Federal Communications Commission (FCC) ruling interpreting the TCPA was invalid. As far as Judge Scola was concerned, all that remained for trial was to determine whether Gulf Coast Collection Bureau had willfully or knowingly violated the TCPA.

Importantly, the *Mais* case had very little to do with HIPAA. Mais was suing for relief under the TCPA, not HIPAA, which does not give the aggrieved party a private right to sue. No judge endorsed the defendants' view that complying with HIPAA automatically means that an entity has obtained "prior express consent" for the purposes of the TCPA.

Gulf Coast Collection Bureau appealed Judge Scola's ruling to a three-judge Eleventh Circuit panel in Atlanta. The Eleventh Circuit reversed Judge Scola's decision, handing a victory to Gulf Coast Collection Bureau and ending Mais' effort to commence a class action.

While the Eleventh Circuit readily accepted Judge Scola's factual findings, it reached a different result primarily because of its determination about the jurisdiction needed to review FCC rulings. As the court explained, Congress had given the FCC broad authority to implement the TCPA via rules and regulations. Over time, the FCC's rules were increasingly predicated on the assumption that if a person knowingly releases her/his phone number, calls are permitted because the person called has essentially requested the contact by providing the caller with their telephone number for use in normal business communications. And in 2008, the FCC expressly concluded that the provision of a cell phone number to a creditor, "e.g., as part of a credit application," satisfactorily demonstrates the needed prior express consent by the cell phone user to be contacted at that number regarding the debt. According to the FCC, it would be critical to determine whether the consumer had provided the cell phone number at issue **during** the transaction that resulted in the debt owed. Needless to say, however, Mais' contact

Creditor Calls to a Patient Unsuccessfully Challenged in Florida continued on page 13

Creditor Calls to a Patient Unsuccessfully Challenged in Florida

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information did come to Westside Regional Medical Center in parallel with his medical treatment.

As discussed above, District Judge Scola had determined that because Mais' action only indirectly concerned the FCC rulings, District Judge Scola had jurisdiction to review and override the FCC's interpretations of the TCPA. But, as the Eleventh Circuit explained, Judge Scola in fact exceeded his jurisdiction. The proper legal question under the Hobbs Act, the statute governing judicial review of FCC rulings, was whether the "practical effect" of a proceeding was to decide the validity of an FCC ruling—*not* whether the FCC ruling was the central issue in a given case. Because it was necessary to evaluate the validity of the FCC ruling in order to resolve Mais' matter, Judge Scola should have recognized he did not have jurisdiction to proceed with the case.

The Eleventh Circuit similarly disagreed with Judge Scola's alternative holding, which was that regardless of the validity of the 2008 FCC ruling, the agency's decision was confined to consumer credit and did not encompass debt for medical services. But as the Eleventh Circuit stated, the FCC's 2008 ruling used very general language and "sends a strong message that it meant to reach a wide range of creditors and collectors, including those pursuing medical debts."

Mais also argued that he did not "provide" his cell phone number to Gulf Coast Collection Bureau because Westside Regional Hospital transmitted it to them, but this argument similarly failed to persuade Eleventh Circuit Judge Marcus, the author of the decision, and his fellow panel members Judges Hull and Hill. "[W]e reject Mais' argument that the 2008 FCC Ruling only applies when a cell phone number is given directly to the creditor," the court said, then pointed out Mais' reasoning would lead to absurd results. "Mais' narrow reading of the 2008 FCC Ruling would find prior express consent when a debtor personally delivered a form with his cell phone number to a creditor in connection with a debt, but not when the debtor filled out a nearly identical form that authorized another party to give the number to a creditor."

Indeed, the FCC ruled earlier in 2014 that the TCPA does not prohibit a caller from obtaining consent through an intermediary. "Ultimately, by granting the Hospital permission to pass his health information [along] for billing, Mais' wife provided his cell phone number to the creditor, consistent with

the meaning of prior express consent announced by the FCC in its 2008 ruling," the Eleventh Circuit determined. "Gulf Coast is entitled to summary judgment precisely because the calls to Mais fell within the TCPA prior express consent exception as interpreted by the FCC."

Finally, the Eleventh Circuit used HIPAA to address Mais' argument that the term "health information" in the hospital's admission forms could not have included his cell phone number. The Hospital's NPP, however, stated that "health information" included "billing-related information," which for the Eleventh Circuit clearly encompassed Mais' cell phone number. The Eleventh Circuit also noted that HIPAA uses a broad definition of "health information" that includes "any information...created or received by a health care provider" that "relates to . . . the past, present, or future payment for the provision of health care to an individual." While the Eleventh Circuit rejected the defendant collection agency's contention that HIPAA compliance automatically ensures that a defendant falls within the "prior express consent" exception to the TCPA, the HIPAA definition of "health information" was relevant because HIPAA was the impetus for the NPP form.

The *Mais* case may be bad news for debtors, but some have hailed it as good news for collection agencies and for the medical industry. In light of the Eleventh Circuit's ruling, health care providers in Alabama, Florida, Georgia, and indeed the country as a whole can be assured that there is strong new precedent that contacting a debtor patient by a cell phone number s/he provided in connection with treatment, even via an automated call, will offend neither HIPAA nor the TCPA. ■

California's Health Information Privacy Law Provides no Nominal Damages for Million Patient Breach

Brooke A. Borders

In *Sutter Health v. Superior Court of Sacramento County*, the Third District Court of Appeals of California considered whether Sutter Health, a hospital system, violated the Confidentiality of Medical Information Act (CMIA) and was liable for nominal damages after losing a computer to theft. Sutter prevailed when the Court of Appeals reversed the trial court's decision to overrule the demurrer and deny the provider's motion to strike. As such, the Court of Appeals dismissed the claim without leave to amend.

In October 2012, a desktop computer was stolen from the Sutter office which contained medical records for more than four million patients. While the computer's hard drive was password-protected, it was not encrypted. Sutter publicly announced the theft, as required under the breach notice provisions of the Health Information Portability and Accountability Act of 1996 (HIPAA), which led to this class action that alleged a violation of the CMIA. HIPAA does not provide for a private right of action, as does CMIA. CMIA provides for an award for nominal damages of \$1,000 to each patient if the provider negligently released such information. Cal. Civ. Code §56.36(b)(1) (2014).

In response, Sutter demurred, arguing that the complaint failed to state a cause of action because it did not allege that an unauthorized viewing of the stolen information occurred. Additionally, Sutter moved to strike the complaint because CMIA only allows individual actions, not class actions.

The trial court overruled the demurrer and held that a cause of action for breach of CMIA was sufficiently pled, regardless of the failure to allege unauthorized viewing of medical information. The court also denied Sutter Health's motion to strike and their petition for writ of mandate, which the Court of Appeals later granted.

Before discussing the application of CMIA to the case at hand, the Third Circuit Court of Appeals briefed the effect of the recently decided Second Circuit opinion of *Regents of University of California v. Superior Court*, 220 Cal. App. 549 (2013), which involved a home invasion where an external hard drive containing 16,000 patient medical records was

stolen, along with a password card. As here, the plaintiffs did not allege that the medical records were viewed by an unauthorized person.

The *Sutter* Court discussed the *Regents'* three-prong analysis, but then adopts its own analysis to reject the plaintiff's claims. The first prong involves the application of section 56.101 of CMIA, which pertains to the health care provider's duty to securely maintain and store the information in a manner that preserves its confidentiality. The *Regents* Court stated that the plaintiff had adequately alleged a violation of that duty to maintain and store medical information, but considered whether such violation subjected the provider to the penalties imposed by section 56.36(b).

The second element focused on the distinction between "disclosure" and "release," as CMIA uses such terms. *Id.* at 564-565. While disclosure requires an affirmative communicative act, the usual and customary meaning of the term "release" used in section 56.36 encompasses a much broader interpretation; whereby a provider "who has negligently maintained confidential medical information and thereby allowed it to be accessed by an unauthorized third person – that is, permitted it to escape or spread from its normal place of storage – may have negligently released the information within the meaning of [the CMIA]." *Id.* at 565.

Lastly, the *Regents* Court held that a plaintiff must plead that an unauthorized person actually viewed records to qualify for an award of nominal damages, reasoning that section 56.36(b) required more than loss of possession to state a cause of action for negligent maintenance or storage of medical information. Thus, the Court held that a plaintiff must plead that the confidential nature of the medial information was a breach due to the negligence of the provider. As a result, the Second Circuit dismissed the claim in *Regents*.

While the Third Circuit arrives at the same conclusion in the *Sutter* case, it does so under a different analysis, namely, finding that without an actual confidentiality breach, a provider

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California's Health Information Privacy Law Provides no Nominal Damages for Million Patient Breach

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has not violated the section 56.101; therefore, the remedy provision of 56.36 is not invoked.

While the plaintiffs attempted to distinguish this case from *Regents*, the Court found the argument unpersuasive because the plaintiff failed to allege the medical information was viewed by an unauthorized person. The court started by applying section 56.10 to the facts of this case. That section states, “[a] provider of health care . . . shall not disclose medical information regarding a patient of the provider . . . without first obtaining authorization . . .” Cal. Civ. Code §56(a) (2014). Although the statute does not define the term “disclosure,” it lists certain circumstances in subsequent subsections, which permit certain disclosures. *Id.* Thus, the Court reasoned that the context and usual meaning of the word “disclosure” implied that section 56.10 required an affirmative communicative act. Since the medical information in this case was stolen, Sutter Health had no intent to disclose and committed no affirmative communicative act.

Secondly, the court noted that the language of section 56.101 made it clear that the preservation of confidential information, not just the prevention of unauthorized possession, was the focus of the legislation. The first sentence of section 56.101(a) states, “[e]very provider of health care . . . who creates, maintains, preserves, stores, abandons, destroys, or disposes of medical information shall do so in a manner that preserves the confidentiality of the information contained therein.” Cal. Civ. Code §56.101(a) (2014). This provision provided that as long as confidentiality is preserved, change of possession is allowed.

This interpretation is consistent with the California Supreme Court decision in *Brown v. Mortensen*, where the Court held that “in order to violate [CMIA], a provider must make an unauthorized, unexcused disclosure of privileged medical information.” 51 Cal. 4th 1052, 1071 (2011). Therefore, the Third Circuit held that possession of the physical form without actual unauthorized viewing of the information does not offend the basic public policy of the CMIA, and therefore, does not constitute a breach of confidentiality. While the plaintiffs argued that possession increased the risk of a confidentiality breach, section 56.101 only provided liability for the failure to preserve the confidentiality of the medical information. Thus, the court held that without actual breach confidentiality, loss of

possession is not actionable under section 56.101.

Additionally, the second sentence of 56.101(a) makes a health care provider liable for negligence. An essential element of negligence is a breach, which causes injury. Since loss of possession does not constitute breach, the plaintiff has suffered no injury and the provider has not satisfied the necessary elements of negligence. The Third Circuit reasoned that to find otherwise would create an unintended result whereby the provider would potentially be liable for \$4 Billion when there was not unauthorized viewing of the information.

The Court concluded by noting that, because Sutter did not violate section 56.101(a), the plaintiff was not entitled to remedies available under section 56.36(b). The Court also considered section 56.26, which provides a remedy of nominal damages when a provider negligently releases information in violation of CMIA. Cal. Civ. Code §56.36(b) (2014). Because there was no actual breach of confidentiality, however, Sutter Health had not negligently released information in violation of CMIA. Thus, the plaintiffs suffered no injury for which any damages, even nominal damages, are available.

In sum, the Third Circuit held that the “disclosure” prohibited under section 56.10(a) required an affirmative communicative act, which is not established when the information is stolen. Additionally, to establish liability for failure to preserve confidentiality, a plaintiff must prove an actual breach of confidentiality, more than a mere change of possession that increases the risk of breach. Without actual breach of confidentiality by unauthorized viewing of medical information, the remedies provided in section 56.36(b) are not available.

Because Plaintiffs failed to allege actual breach of confidentiality or demonstrate a reasonable possibility that they could plead breach of confidentiality, the Third Circuit concluded that Sutter Health's demurrer must be sustained without leave to amend and dismissed the case. ■



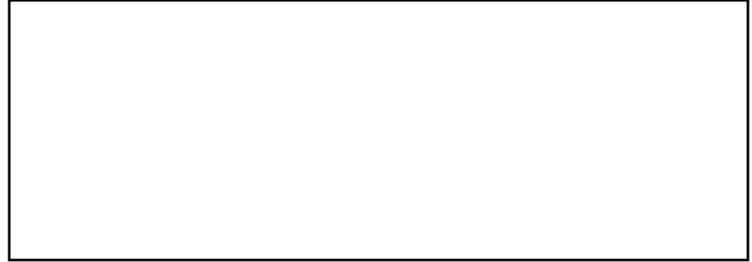
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