HEALTH LAW
AMERICAN BAR ASSOCIATION YOUNG LAWYERS DIVISION

AMERICAN BAR ASSOCIATION
Young Lawyers Division

Committee Newsletter | Spring 2016

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What I Wish I Had Known

By C. Joyce Hall
Chair-Elect, 2015-2016 ABA Health Law Section

> *The YLD Health Law committee asked senior healthcare lawyers what they wished they had known as a younger attorney. In Part Three of this series, Joyce C. Hall summarizes the lessons she has learned practicing as a healthcare lawyer and explains her daily mantra.*

"Never let them see you sweat." With that famous quote (from the '80s) I have affirmatively defined myself as an "older" lawyer and explained the reason I was asked to share my thoughts with you on "what I wish I had known" as a younger lawyer. The quote was the tagline for the advertising campaign launched by The Gillette Company for Dry Idea antiperspirant in 1984, the year I entered law school. Picture an appropriate emoji in this spot. The ad campaign featured celebrities who grabbed the audiences' attention with advice on three "Nevers" to being _____ (fill in the blank – a fashion designer, a famous comedian, a winning coach, etc.). You can view the ads on YouTube for the celebrities' sage advice.

As I began my law career this quote quickly became my motto. Keeping with that tradition, permit me share with you three "Nevers" I wish I had known as a young lawyer.

1. Never pass on an opportunity to learn from a lawyer you admire. In today's fast-paced world, we tend to prioritize those things that are tugging hardest or screaming loudest for our immediate attention and we don't take the time to study how a lawyer with more experience handled a difficult situation, responded to a delicate subject, or explained a complex legal concept. Take the time to watch, ask questions, and study why someone took a particular approach. Sometimes the best teacher is sitting in the office next door. Never forget to appropriately appreciate the team that helps you achieve your best each day—your family, your assistants, and your fellow associates. Your best advice on how to practically accomplish a task may come from the legal assistant who has been doing it for 20 years or the clerk in the filing office. Get to know these folks and, more importantly, appreciate the assistance they give. One day you may be in a pinch and need some extra assistance. The people you have treated with respect will most likely be happy to assist in the crisis.

2. Never assume you can "wing it." Always be overly-prepared so you can speak from the overflow, respond to unexpected situations from a position of knowledge instead of defensiveness, and demonstrate to your client that you care about their particular situation because you have spent the time to learn their business. Clients want a lawyer who will work hard to accomplish the task and give sound advice. Laziness has no place in the attorney-client relationship. Practicing in a highly regulated field like health law makes it especially challenging to stay current on the latest regulations and guidance from the government agencies. Establish a routine early in

your career for keeping abreast of the latest developments. Don't rely simply on someone else's evaluation of the regulations or guidance. Read the regulations for yourself. You might catch a nuance that is the key to the answer for your client's problem.

3. Everyone feels pressure, but "never let them see you sweat." So what does that mean? All lawyers get at least a little nervous at times. In fact, a few butterflies keep you on your toes. But don't let this profession rob you of your joy in serving your clients. Find a work/life balance that helps you relieve the stress and find fulfillment in your job and your family. Keep your priorities in the proper order. Remember no one ever says on their death bed that they wished they had spent more time at the office. We are "healthcare lawyers" but making sure that we keep ourselves healthy – including physical, mental and emotional health – is as important to our clients as knowing the law. Some of the best business development you will do for your firm will come from the relationships you forge outside of your law school friends and the legal circles you travel during working hours. Another lesson from this "Never" is to be careful not to let this profession go to your head. "Never let them see you sweat" doesn't mean that you are the only one with the right answers or the only one who can do the job. Clients want a confident lawyer but not an over-confident lawyer. There is a distinction.

Being a healthcare lawyer can lead to a very rewarding career. The law is challenging, but the importance of the work that our clients seek to accomplish in helping to keep our communities healthy cannot be overstated. Providing advice to assist a healthcare client pursue his or her mission of building a healthier society is an honorable profession indeed. I wish you all the best in your health law careers.

About the Author: Ms. Hall is a member of Watkins & Eager, PLLC, where she practices in the areas of commercial transactions, public finance, corporate and health care law. Ms. Hall currently serves as the ABA Health Law Section Chair-Elect.

Lights, Camera, Action!
The Implied Certification Theory Takes Center Stage

By Joshua G. McDiarmid

Another day, another case asserted under the False Claims Act ("FCA") – and, yet again, it is a case with massive implications. *Universal Health Services, Inc. v. United States and Massachusetts, ex rel. Julio Escobar and Carmen Correa,* which has now wended its way up to

the Supreme Court of the United States, will finally provide a definitive answer to the validity and application of the implied certification theory of FCA liability.[1]

As an initial matter, a brief refresher for those who would otherwise have to Google the terms "implied certification theory": it is a theory of liability which provides that a party may be held liable for violating the FCA where that party has made a request for payment despite its noncompliance with applicable statutes, regulations, or contract provisions that are material preconditions to payment. Easy enough, right?

Escobar, if anything, could hardly be riper for the picking. Indeed, ten of the thirteen federal circuits have weighed in on the implied false certification doctrine. Within these ten federal circuits, there are three distinct camps. In the First, Fourth, and D.C. Circuits, any knowing and material breach or violation of a contract, statute, or regulation that can be viewed as prerequisite to payment can give rise to liability.[2] In contrast, the Second, Third, Sixth, Ninth, Tenth, and Eleventh Circuits apply a narrower view of the doctrine, rejecting liability based on implied certification of compliance with regulations that are conditions of federal government program participation, and instead limiting the application of the doctrine to situations where compliance with the applicable statute, regulation, or contract provision is an express prerequisite to payment.[3] The only outlier at this time is the Seventh Circuit, which has potentially rejected the doctrine.[4]

With the stage set, a little bit about *Escobar*, the FCA, and the application of the FCA to *Escobar*. The genesis of this particular FCA case was the care of Relators' daughter at Arbour Counseling Services ("Arbour"), a subsidiary of Universal Health Services, Inc. ("UHC"). Relators alleged that their daughter – who died of a seizure in 2009 – was treated by various unlicensed and unsupervised staff, in violation of state regulations. The crux of their complaint is that Arbour's alleged noncompliance with certain supervision and licensure requirements

[1] 780 F.3d 504 (1st Cir. 2015), *cert. granted in part*, No. 15-7, 2015 WL 4078340 (U.S. Dec. 4, 2015).
[2] *See*, *e.g.*, *U.S. ex rel. Hutcheson v. Blackstone Medical, Inc.*, 647 F.3d 377 (1st Cir. 2011); *U.S. v. Triple Canopy, Inc.*, 775 F.3d 628 (4th Cir. 2015); *U.S. v. Science Applications Intern. Corp.*, 626 F.3d 1257 (D.C. Cir. 2010).
[3] *See Mikes v. Straus*, 274 F.3d 687 (2nd Cir. 2001); *U.S. ex rel. Wilkins v. United Health Group, Inc.*, 659 F.3d 295 (3rd Cir. 2011); *U.S. ex rel. Augustine v. Century Health Servs., Inc.*, 289 F.3d 409 (6th Cir. 2002); *Ebeid ex rel. U.S. v. Lungwitz*, 616 F.3d 993 (9th Cir. 2010); *U.S. ex rel. Conner v. Salina Reg'l Health Ctr., Inc.*, 543 F.3d 1211 (10th Cir. 2008); *McNutt ex rel. U.S. v. Haleyville Med. Supplies, Inc.*, 423 F.3d 1256 (11th Cir. 2005).
[4] *See United States v. Sanford-Brown, Ltd.*, 788 F.3d 696 (7th Cir. 2015) ("Although a number of other circuits have adopted this so-called doctrine of implied false certification, we decline to join them and instead join the Fifth Circuit.") (internal citations omitted). Notably, the stance of the Fifth Circuit is not quite as clear as the Seventh Circuit alleges it to be. *See*, *e.g.*, *United States ex rel. Gage v. Davis S.R. Aviation, LLC*, Civ. A. No. 14-50704, 2015 WL 4237682 (5th Cir. July 14, 2015) ("[T]his court has avoided deciding whether to recognize the implied certification theory.").

rendered its reimbursement claims submitted to the state Medicaid agency, MassHealth, actionably false under both the federal and Massachusetts FCA.

The district court dismissed the Relators' complaint, reasoning that the regulations violated by defendant were merely requirements for participation in MassHealth, not "preconditions to payment." The United States Court of Appeals for the First Circuit reversed and remanded, holding that the regulations were conditions of payment and "each time [Arbour] submitted a claim, [it] implicitly communicated that it had conformed to the relevant program requirements, such that it was entitled to payments." Ultimately, the Supreme Court granted *certiorari* on two questions:

1. "Whether the 'implied certification' theory of legal falsity under the False Claims Act – applied by the First Circuit below but recently rejected by the Seventh Circuit – is viable?"

2. "If the 'implied certification' theory is viable, whether a government contractor's reimbursement claim can be legally 'false' under that theory if the provider failed to comply with a statute, regulation, or contractual provision that does not state that it is a condition of payment, as held by the First, Fourth, and D.C. Circuits; or whether liability for a legally 'false' reimbursement claim requires that the statute, regulation, or contractual provision expressly state that it is a condition of payment, as held by the Second and Sixth Circuits."

With these issues in mind, it is perhaps helpful to briefly discuss the FCA. The FCA, originally enacted in 1863 "with the principal goal of stopping the massive frauds perpetrated by large [private] contractors during the Civil War," *Vermont Agency of Nat. Res. v. United States ex rel. Stevens*, 529 U.S. 765 (2000) (alteration in original), imposes liability on any person that has engaged in certain types of fraudulent activity against the federal government. As pertinent in *Escobar*, the FCA makes liable any person who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval." A defendant may be found to have acted "knowingly" if the defendant acts with actual knowledge of false information, in deliberate ignorance of the truth or falsity of information, or with reckless disregard of the truth or falsity of the information. *See generally*, 31 U.S.C. § 3729. Counsel for the UHC, Roy T. Englert Jr., succinctly summarized the issue to the Supreme Court – "[t]his entire case turns on four words of the statute: 'False or fraudulent claim.'"

Before addressing the oral arguments head-on, there are a handful of "jots and tittles" (to borrow language from Mr. Englert) that make this case particularly interesting. First, the Court of Appeals for the First Circuit, in reversing the district court, relied on 130 Mass. Code Regs. § 429.423(B)(2) – a regulation that was not cited in the complaint, in any appellate brief filed with the First Circuit, or in the *amicus* brief filed by the Commonwealth of Massachusetts. In other words, the First Circuit effectively found that Arbour made a fraudulent and false request for payment when it failed to comply with a regulation that no one, other than the First Circuit, even noticed. Arguably, it is challenging to understand how such a "material" regulation eluded so many sets of eyes. Second, the serious ramifications of a claim implicating liability under the FCA are brought front and center in *Escobar*. Specifically, before the Relators asserted their

claim under the FCA, there were only two minor penalties that stemmed from their daughter's untimely death: one individual had to pay a $1,000.00 fine, and the claimant director for Arbour was given two years supervision. Through the "magic of the implied certification theory under the [FCA]" – again, to quote Mr. Englert – "the very same facts have now been recharacterized as fraud on the government." In other words, but for liability under the FCA, Arbour would have walked out with nothing more than a slap on the wrist.

The Supreme Court heard oral arguments on April 19, 2016. Not surprisingly, it is difficult to say with a high degree of certainty which direction the Justices are leaning. Justices Thomas and Alito were silent. Justice Ginsburg asked just one question. Justice Kennedy asked a handful of questions – however, there was no obvious motive behind his inquiries. The bulk of the questions were asked by the remaining Justices, specifically, Chief Justice Roberts, and Justices Breyer, Sotomayor, and Kagan. It appears that the Seventh Circuit – which has potentially rejected the implied certification theory of liability – will remain an outlier. From the beginning, none of the Justices suggested that the implied certification theory was wholly invalid. Instead, the Supreme Court focused on the second question presented and, in particular, the practical implications of how to determine when a violation of a particular regulation could support liability under the FCA.

The questioning, by and large, appeared to assume that a provision expressly conditioning payment on compliance with an underlying regulation would support FCA liability. In other words, the narrower view taken by the Second, Third, Sixth, Ninth, Tenth, and Eleventh Circuits was not contested. Rather, the Supreme Court focused on when, absent an express provision, a regulation is nevertheless a condition of payment. Justice Breyer quickly honed in on the heart of the matter: "[t]hat's to me what's at the heart of this. How do you distinguish those regulations, breach of which are fraudulent when you breach them, and implicitly promise not to, from those that [are] not? There are millions of regulations."

Justices Sotomayor and Kagan were plainly skeptical of UHC's argument that there could be no "false or fraudulent claim" without some affirmative misstatement. In other words, UHC argued that the basic legal principles of fraud should govern, such that claims cannot be "false or fraudulent" without a false statement or a duty to disclose some other fact, even if the person fails to satisfy every potentially applicable regulatory or contractual requirement. Justice Sotomayor, thoroughly unconvinced, inquired:

> **Justice Sotomayor:** I'm sorry. I'm totally confused. I always thought that when you asked for payment, you're making a promise: I did what I agreed to do. Pay me, please.
>
> That's, to me, what's sort of understood. If I hired you to provide me with doctor services, you ask me for money, I'm assuming you provided me with doctor services. And you know you didn't. Why isn't that fraud?

Similarly, Justice Kagan posed the following hypothetical, challenging UHC's argument:

Justice Kagan: Justice Sotomayor said the government contracts to buy guns; the guns don't shoot. The government contracts to buy boots – this was all within the context of the Civil War – the boots fell apart after 12 hours. The government contracts to buy food; the food was rancid.

And each of those contractors would come in and would demand payment.

And the entire idea behind this statute is that in that demand of payment is a representation. The representation is that I've given you guns that shoot and boots that wear and food that can be eaten. And when – when that is not true, that is a fraudulent claim. And you're suggesting that all these hypotheticals – that somehow that's not a fraudulent claim. And I guess that leaves me sort of wondering what do you think would be a fraudulent claim?

In its analysis, the Supreme Court expressed little interest in the various tests and limitations employed by the lower courts. However, there seemed to be a consensus among the Justices that a contractor makes an implicit representation of compliance, with at least some subset of contractual terms and regulations, when it submits claims for payment to the government, i.e., that the guns can shoot, that the boots will wear, that the food can be eaten, and that a doctor's care is a doctor's care. Accordingly, the Justices appreciably narrowed the issue for us: how do you distinguish a regulation that will trigger FCA liability from one that will not? There was some discussion of limiting liability under the FCA to a material breach – however, materiality is already defined in the FCA, and the definition provided therein is significantly less stringent than the common law definition. Mr. Englert proposed an "essentiality test," whereby only those contractual terms that go "to the basis, or essence, of the transaction" could support an implied certification term. In other words, a gun that can shoot is an essential part of a contract for guns.

In any event, however, I am remiss to say that I am not a mind reader, fortune teller, scryer, or some other person capable of discerning the future. Accordingly, we are going to have to wait until June before we get to see how this show ends.

About the Author: Mr. McDiarmid is an associate at Kantrow, Spaht, Weaver & Blitzer in the firm's Commercial Litigation practice group. Mr. McDiarmid's practice includes aspects of health care law, including health care litigation.

Privacy and Security Guidance Concerning Mobile Health Apps

By Ashley L. Thomas
YLD Liaison, Physician Issues Interest Group, ABA Health Law Section

By 2017, fifty percent of smartphone users will have downloaded mobile health applications ("apps").[5] The mobile health market is expected to generate around twenty-six billion dollars in revenue in 2017.[6] As technology is evolving, there has been a proliferation of medical and health-related apps that are intended to increase patient engagement, improve outcomes, and reduce healthcare costs. According to former U.S. Secretary of Health and Human Services Kathleen Sebelius, mobile healthcare technology is the "biggest technology breakthrough of our time" and can be used to "address our greatest national challenge."[7] According to a recent report, around eighty percent of physicians have adopted the use of smartphones and medical apps and an even greater percentage of physicians believe that mobile health apps can improve a patient's health.[8] Despite the widespread adoption of mobile health apps, there isn't much guidance on how this technology is regulated. In an effort to overcome any confusion on how mobile health apps are regulated, several government agencies have recently released further guidance on how mobile health technology is regulated under federal law.

Mobile app developers received some legal guidance on the type of security features that should be provided in mobile health apps when the Federal Trade Commission ("FTC") in partnership with the Office of National Coordinator for Health Information Technology, the U.S. Department of Health and Human Services Office for Civil Rights ("OCR") and the U.S. Food and Drug Administration ("FDA") recently released an online tool intended to help app developers understand the federal regulations that may concern their apps.[9] The interactive web-based tool walks developers through a series of simple questions with the purpose of helping app developers figure out which federal law may be applicable to them. The FTC guidance focuses on the Health Insurance Portability and Accountability Act ("HIPAA"), the Federal Food, Drug, and Cosmetic Act ("FDCA"), the Federal Trade Commission Act, and the FTC's Health Breach Notification Rule.

The first question asks developers if the purpose of the app is to create, receive, maintain or transmit identifiable health information. This question concerns HIPAA which protects the privacy and security of certain health information and requires covered entities to provide notifications of health information breaches. The next three questions also focus on HIPAA by posing questions to developers on how to assess whether they will be considered a covered

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[5] GreatCall, *Is Mobile Healthcare the Future?*, http://www.greatcall.com/greatcall/lp/is-mobile-healthcare-the-future-infographic.aspx (last visited May 28, 2016).
[6] *Id*.
[7] Serena Marshall, *Doctor on Your Smart Phone 'Within Sight,' Sebelius Says*, ABC News (Dec. 6, 2011), available at https://www.yahoo.com/news/blogs/abc-blogs/doctor-smart-phone-within-sight-sebelius-says-160117674.html.
[8] GreatCall, *supra* note 5.
[9] Federal Trade Commission, *Mobile Health Apps Interactive Tool*, https://www.ftc.gov/tips-advice/business-center/guidance/mobile-health-apps-interactive-tool (last visited May 28, 2016).

entity or business associate. The fifth, sixth, and seventh questions help developers understand how their app may be regulated by the FDA, the agency that enforces the FDCA. The FDA oversees the safety and effectiveness of medical devices, including certain mobile health apps. Mobile health apps that are intended to be used in the diagnosis, cure, or prevention of diseases or other conditions are regulated by the FDA. Mobile health apps that pose a minimal risk to a user are not going to be heavily scrutinized by the FDA. Minimal risk apps include: helping users self-manage their disease or condition; simple tracking of health information; and automating simple tasks for healthcare providers. The last three questions help the developer determine if the app will be regulated by the FTC. If the app offers consumers access to their health records directly, then the app will be subject to the Health Breach Notification Rule. This Rule requires a personal health record provider to notify consumers and the FTC of a breach of unsecured personal health information.

According to Jessica Rich, director of the FTC's Bureau of Consumer Protection, "Mobile app developers need clear information about the laws that apply to their health-related products. By working with our partner agencies, we're helping these businesses build apps that comply with the law and provide more protection for consumers."[10] While the FTC tool is simple and easy to follow for insight into some federal regulations, the tool did not address all applicable federal laws or state law implications for developers. The tool did not pose questions concerning financial relationships between the parties developing the app and other healthcare providers, issues relevant to the Anti-Kickback Statute and Stark Law. Developers should also be cognizant of applicable state laws that may affect their app.

At the end of the questioning, developers can access the FTC's Best Practices Guide which emphasizes the importance of developing sound privacy and security practices for mobile health apps. Developers are encouraged to minimize data collection and make reasonable efforts to de-identify data. If data collection is integral to the app, then developers need to create security features for transmitting and storing the data. Developers are advised to invest resources in the design, implementation, and testing of authentication. Developers need to consider how to ensure that a person accessing a particular account is the legitimate owner of the account. The FTC suggests multi-factor authentication as a way to validate access by requiring the use of a password and separate code sent via another channel, such as an email or text. In addition, the FTC urges developers to incorporate data security at every stage of the app's lifecycle from design, development, and launch to post-market. Testing security measures before launching the app and continuing to evaluate the security of the app with usage is strongly encouraged. In contrast to the online tool, the best practices guide mentions that developers should analyze other applicable federal laws including state laws and how it may affect the app.

In October 2015, the OCR launched an online portal for mobile health app developers to pose questions to the agency regarding compliance with HIPAA privacy and security requirements.

[10] Sean Murray, *FTC Launches Tool to Help Mobile Health App Developers Determine Applicable Regulations*, Pharmafile (April 8, 2016), available at http://www.pharmafile.com/news/503825/ftc-launches-tool-help-mobile-health-app-developers-determine-applicable-regulations.

The purpose was twofold: to provide developers a platform to clarify their understanding of HIPAA while also allowing the OCR to gain insight into issues that are puzzling developers. The OCR released additional guidance in February 2016 titled "Health App Use Scenarios & HIPAA," which builds on the developer portal to further clarify any confusion over HIPAA.[11] The guidance provides a list of scenarios to identify when an app developer is and is not considered a business associate. The guidance was intended for developers to consider two important questions: (1) how does HIPAA apply to health information that a patient creates, manages, or organizes through the use of a health app, and (2) when might an app developer need to comply with the HIPAA Privacy and Security Rules. Healthcare providers or health plans that hire app developers to offer or facilitate their services will be considered a business associate and subject to applicable requirements. If the app is not being created or utilized on behalf of healthcare providers or health plans, then the developer will not be considered a business associate. The guidance ends with the following questions that app developers should consider in determining whether they may be a business associate:

- Does your health app create, receive, maintain, or transmit identifiable information?
- Who are your clients? How are you funded?
- Is your app independently selected by a consumer?
- Does the consumer control all decisions about whether to transmit her data to a third party, such as to her health care provider or health plan?
- Do you have no relationship with that third party entity?

The guidance from the OCR and the FTC signal the agencies will likely be actively monitoring mobile health apps in the future. Mobile app developers and healthcare technology companies should seek legal counsel over any confusion that remains with respect to compliance with federal and state laws.

About the Author: Ashley Thomas is an associate at Hall, Render, Killian, Heath & Lyman. She practices in the area of healthcare law with a focus on hospital and health system matters, regulatory and compliance issues, corporate transactions, and hospital/physician alignment.

[11]U.S. Dep't Health & Human Servs., *Health App Use Scenarios & HIPAA*, http://hipaaqsportal.hhs.gov/community-library/accounts/92/925889/OCR-health-app-developer-scenarios-2-2016.pdf.

STUDENT SPOTLIGHT:

Dying for Some Privacy

By Shari Esquenazi
J.D. Candidate, South Texas College of Law

The latest version of reality television is raising eyebrows and issues of health law. Shows, such as NY Med, feature a camera crew that follows around and documents "real life" emergency situations, including the final moments of patients' lives. Hospitals exalt the publicity harnessed from airing these shows, publicity which they claim is unparalleled by traditional advertising methods. The networks support their shows by claiming that the shows boost the morale of the city by praising emergency services and city hospitals. The networks also assert that their shows encourage viewers to pursue careers in medical fields which will save more lives.[12]

Yet these shows are also criticized as capitalizing on the loss of loved ones. Family members who have relived the death of a loved one via public television have a vastly different perspective from those profiting from the experience. Legally, the primary issue with these shows is that patients and their families often do not give authorization or consent for their experience to be filmed and disclosed, much less broadcast across the nation on a major television network. The lack of consent raises important concerns under the federal Health Insurance Portability and Accountability Act ("HIPAA"), as well as state privacy laws.

HIPAA serves to protect medical records and other health information provided to health plans, doctors, hospitals, and other health care providers. HIPAA also safeguards medical information by providing patients with access to their own medical records and the power to execute control over how their health information is used and disclosed. Consent plays a critical role here; a patient must provide authorization for their information to be shared.[13]

HIPAA and state privacy laws were at the heart of the lawsuit filed by the Chanko family against "real life" medical drama, NY Med. In April 2011, Mark Chanko was struck by a sanitation truck while crossing a street near his home.[14] The doctors and nurses at New York Presbyterian Hospital/Weill Cornell Medical Center tried to save his life, but their efforts were unsuccessful. This was nothing out of the ordinary, on its own. This patient, however, was featured on an episode of NY Med that was watched by an unsuspecting Anita Chanko, his wife. Mrs. Chanko was watching the television show when she recognized her husband's physician, who was responding to an emergency in which a man was hit by a vehicle; the facts of the situation matched those of her husband's final moments. Mrs. Chanko and her children could easily recognize the man who was moaning in pain and asking for his wife as Mr. Chanko.

[12] Charles Ornstein, *Dying in the E.R., and on TV without His Family's Consent*, NY Times (Jan. 2, 2015).
[13] The Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.
[14] *Chanko v. Am. Broad. Companies Inc.*, 997 N.Y.S.2d 44 (2014), aff'd as modified, No. 44, 2016 WL 1247664 (N.Y. Mar. 31, 2016)

Neither Mr. Chanko nor anyone in the Chanko family had given NY Med permission to film Mr. Chanko's emergency treatment. HIPAA and state privacy laws regulate these intimate moments and permits them to be shared with only whomever the patient designates. Violations of the HIPAA Privacy Rule carries significant penalties for the healthcare provider (known as a "Covered Entity"). These penalties include civil money penalties, criminal fines, and even prison time. As substantial as the statute is, and as grave as its potential penalties are, Congress opted not to include a private right of action, effectively preventing private individuals from suing others specifically for violating HIPAA. However, some state privacy laws do provide a private right of action, so long as the person whose privacy was violated can show calculable damages.

The Chankos sued ABC, the hospital, and the treating emergency physician for damages, asserting the state tort theory of intentional infliction of emotional distress ("IIED"). A cause of action for IIED requires the establishment of four elements, "(1) extreme and outrageous conduct; (2) intent to cause, or disregard of a substantial probability of causing severe emotional distress; (3) a causal connection between the conduct and injury; and (4) severe emotional distress."[15]

In court filings, the hospital and ABC did not claim that they had received consent from the patient or his family, but instead claimed that the patient was not identifiable to the public. The network further argued that because NY Med is produced by its news division, it is protected by the First Amendment of the U.S. Constitution. Moreover, the network said that the Chankos were directly responsible for their loss of privacy, and that no identification of the patient or family would be public if it was not for the family's publication via the lawsuit. The network further argued that claims alleged are merely incidental disclosures, but that they have taken the necessary precautions to prevent an identity from being revealed, including blurring faces and tattoos. ABC blamed the Chankos for their loss of privacy, asserting that no identification of the patient would be public if it was not for the family's publication via the lawsuit.

The Chankos argued that blurring out Mr. Chanko's face did not effectively protect his identity. A pet sitter of the family called Mrs. Chanko a few weeks after the original air date of the show asking if the man in that episode was indeed her husband.

The Chanko's case was dismissed, and the family appealed. The appellate court ordered a dismissal of the IIED claim, noting that the conduct was "not so extreme or outrageous" to justify a tort claim of IIED.

Officials with the New York health department concluded that the hospital had indeed violated Mr. Chanko's rights, and its own privacy policy. The patient was unaware and uninformed that he was being observed and filmed by a camera crew for the purpose of developing a television show while he received medical treatment. Thus, his privacy in receiving medical treatment was not ensured. New York regulators did not impose any sanctions on the hospital, however, because New York State's Patients' Bill of Rights gives patients the right to sue if hospitals or doctors violate their policy.

[15] *Howell v. N.Y. Post Co.*, 81 N.Y.2d 115, 121, 612 N.E.2d 699 (1993).

Aside from breaching legal protections, there are numerous ethical and medical concerns involved with these shows. This is an abuse of trust in an already vulnerable set of circumstances. These issues are exacerbated by the presence of the camera crews in the treatment areas. Undoubtedly, the camera crews are vectors of contamination. To allow a camera crew in a trauma room is inconsistent with the sanitation policies which prevent husbands and wives from being allowed to hold their loved one's hand during their final moments. An additional concern with the presence of a camera crew in an already crowded trauma room is the potential distraction and its impact on patient care. The medical team ought to be focused on saving the patient's life, not looking good for television.

Violations of HIPAA privacy rules carry significant penalties, including civil money penalties, criminal fines, and even prison time. However, the lack of a private cause of action effectively allows hospitals and doctors to be held accountable only by state privacy laws for what some would consider taking advantage of the seriously injured or dying in exchange for advertising and financial gain. In order to hold these parties to a higher standard, actionable state and federal laws ought to be developed in order to protect patients and their families. At the very least, sculpting a rule which requires consent before filming and airing medical treatment would go a long way.

About the Author: Shari Esquenazi is a first-year law student at South Texas College of Law in Houston, Texas, where she serves as the President of the Health Law Society. She is an alumna of Yale University's Summer Institute in Bioethics and will be working at MD Anderson Cancer Center as an intern the summer of 2016. She has been passionate about medicine, ethics, and health policy since she was an undergraduate student majoring in anthropology and biology with minors in psychology and philosophy.

In her free time, Shari enjoys being with her loved ones and is inseparable from her overweight cat, Zavi. She plays ukulele and piano, and performs stand-up comedy routines for fun with her boyfriend. Shari enjoys trying different coffee shops out and considers herself an espresso connoisseur. She appreciates the challenge of baking intricate pastries and cakes and hopes to open up a joint café and bar later in life.

After law school, Shari wants to pursue a post-doctoral program in health law and bioethics. Having enjoyed working in hospital environments throughout her academic career, she wants to work as counsel in a hospital while simultaneously serving on an ethics committee and teaching students about bioethical issues and health law.

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NEWS AND ANNOUNCEMENTS

Get Involved!

Call to Authors
Do you have a Health Law article or topic of interest? Submit your article to the ABA YLD Health Law Committee for publication in our Newsletter. The ABA YLD Health Law Committee has several opportunities for young lawyers to be published. This is a great opportunity for young lawyers to get published and get noticed! Email Dani Borel at Danielle.borel@bswllp.com.

Call for Ideas
How can the ABA YLD Health Law Committee serve you better? Would you like more articles, teleconferences, emails? Would you like to join an email list to discuss Health Law issues with other practitioners? Let us know! Email Stephen Angelette at SAngelette@Polsinelli.com.

In the Works
The Health Law Committee leadership is currently in the works with developing a mentor/mentee program with the ABA Health Law Section. The program will be designed to create a mutually beneficial relationship between a junior and senior lawyer. For junior lawyers, it is a chance to publish an article or speak with a senior lawyer, expand their network, receive thoughts and advice in a particular focused practice area, and receive advice on their career goals in health law generally. Stay tuned!

Upcoming Events

05/23/2016—Changes to Physician Reimbursement Under CMS's MACRA Proposed Rule
Webinar, 1.50 CLE Hours

On April 27, 2016, the Centers for Medicare & Medicaid Services issued a proposed rule that would implement changes to reimbursement under the Medicare Physician Fee Schedule as required by the Medicare Access and CHIP Reauthorization Act of 2015. MACRA and its implementing proposed rule will have a significant impact on the way that physicians will be reimbursed going forward. The webinar will address the material data reporting and compliance obligations that physicians would have under the new rule.

05/24/2016—Top 3 Online Marketing Strategies for New Attorneys
Webinar

Free! Learn from a panel of experts and successful attorneys about the top 3 online marketing strategies all attorneys should know – especially those who have recently launched their firm or are considering doing so. Hear real-life attorney tactics that reveal practical solutions for generating new clients and growing your practice. Plus

get a sneak peak at results from the 2016 State of Online Marketing survey of 300+ Martindale-Nolo clients regarding their firms' marketing initiatives.

05/25/2016—Trauma-Informed Legal Practice: Communicating with Children Who Have Experienced Trauma
Webinar, 1.50 CLE Hours

Free! Many young clients have experienced trauma, particularly those involved in the child welfare or juvenile justice systems. Trauma can affect the most fundamental aspects of the attorney-client relationship. A working understanding of trauma, including its origins and impacts, can help lawyers anticipate and respond to trauma's effects as they surface. The webinar focuses on practical strategies for communicating with young clients who have experienced trauma.

06/06/2016—Healthcare Policy 2016 The Legislative and Regulatory Agendas

Free! An overview of key Congressional and Administration healthcare policy issues likely to be active in 2016. Congressional issues include budget resolutions, appropriations, Medicare policy and FDA policy. Administration policy issues include CMS regulation of Medicare and Medicaid payment systems and FDA regulation of devices and drugs. Discussion will also preview possible policy consequences of the 2016 election.

06/07/2016—Health Care Litigation Under ERISA and the ACA
Webinar, 1.50 CLE Hours

Panelists will discuss ACA discrimination, retaliation and whistleblower claims under the ACA § 1558 and ERISA § 510; benefit claims based upon ACA benefit mandates; and claims arising from a plan's inadvertent loss of grandfathered status. Panelists will also discuss in-network and out-of-network providers who litigate pay and reimbursement disputes against insurance companies using ERISA.

06/07/2016—Recent International Antitrust Developments in Health Care and Pharmaceuticals -- 2016 Update

Second installment of the International Antitrust Developments Initiative, a series of semiannual programs on antitrust developments in health care and pharmaceuticals markets outside of the U.S. It has become paramount to approach antitrust issues from a global perspective in these markets; companies deal with many of the same core antitrust issues inside and outside of the U.S. but are often subject to varying standards and levels of enforcement. This new initiative aims to provide in-house and external antitrust practitioners with a solid understanding of key differences across jurisdictions, as well as an overview of major developments.

06/08/2016-06/10/2016— 11th National Institute on the Civil False Claims Act and Qui Tam Enforcement
In-Person Conference, 11 CLE Hours

The Civil False Claims Act (FCA) is the fastest growing area of federal litigation, particularly because of its unique qui tam enforcement mechanism. Amendments in

2009 made this law even more powerful. The 11th National Institute will bring together experts from all areas—DOJ, state AG offices, federal agencies, leading defense and plaintiff firms—to discuss this ever-growing area of litigation and enforcement.

06/09/2016-06/10/2016— 2016 Physicians Legal Issues Conference
In-Person Conference

This unique program offers physicians, attorneys and their administrative partners an opportunity to hear how these issues are being addressed by physicians and how physicians can succeed at maintaining viable medical practices that offer quality services at their core. As a combined educational program with the American Bar Association, Health Law Section, the Chicago Medical Society and the American Association for Physician Leaders, physicians and their legal counsel will have access to national speakers and will be educated on key issues affecting employer and hospital relationships, business and industry responses to payer consolidation and market control, and every day "survival" techniques in hospital and private practice settings.

06/16/2016— HIPAA, Privacy and Security Fundamentals
Webinar, 1.50 CLE Hours

The webinar will include information about what steps your organization can take in light of HIPAA's requirements and heightened enforcement activity to ensure compliance within your organization. The HITECH Act has significantly expanded the government's enforcement reach for HIPAA compliance. If your clients are touching "Protected Health Information," you'll want to understand what they need to do to comply.

07/12/2016— The Final Answers: The Supreme Court ERISA and Litigation Decisions
Webinar, 1.50 CLE Hours

Panelists will analyze the Supreme Court decisions affecting ERISA plans, participants, and providers, evaluate their impact on future litigation, discuss steps clients should take in response to the decisions, and gaze into the crystal ball for next Term's cases. The cases to be discussed include:

- Preemption: *Gobeille*
- Equitable remedies and overpayments: *Montanile*
- Employer securities and Pleadings: *Amgen*
- Litigation Procedure and Class Actions: *Spokeo*, *Tysons Food*, & *Gomez*
- Contraceptive Cases

08/04/2016–08/07/2016—2016 ABA YLD Annual Meeting
In-Person Conference

San Francisco, CA