MESSAGE FROM THE CHAIR

By Paula G. Sanders
Wolf, Block, Schorr & Solis-Cohen, LLP

This fall and winter promises to be one of the most active periods in the Committee’s history. On Oct. 13, 1999, the Committee presented a two-hour program on “Updates in Long Term Care: Recent Revisions in State Regulation and Federal Procedures.” Lori McLaughlin, Chief Counsel to the Pennsylvania Department of Health (“DOH”), and I led the discussion and exploration of the DOH’s new licensure regulations governing long term care facilities, as well as the Health Care Financing Administration’s implementation of a new survey and certification protocol and use of Quality Indicators. The Hon. Robert P. Casey Jr., Auditor General, attended the session.

In an effort to serve our members throughout the State, the Committee will be sponsoring two Lunch ’n Learns on Nov. 30, 1999, in Philadelphia and Pittsburgh. The Philadelphia program, “Changing Liability Landscape for Managed Care,” is chaired by Renee H. Martin, and features Ernest T. Tsoules Jr., Brad X. Terry and Joshua M. Spielberg. This program will examine current and emerging theories of managed care liability exposure in the areas of fraud and abuse in a capitated system and under

continued on Page 2

Pennsylvania Supreme Court Decides Three Cases Under the Mental Health Procedures Act

By Howard Ulan
Commonwealth of Pennsylvania Department of Public Welfare

In the last twelve months, the Supreme Court of Pennsylvania has issued three decisions addressing central questions about the Mental Health Procedures Act of 1976 (MHPA), 50 P.S. §§ 7101 et seq., and related statutes: (1) When, if ever, does a psychotherapist have a duty to breach confidentiality in order to protect a third party? Emerich v. Philadelphia Center for Human Development, Inc., et al., 720 A.2d 1032 (Pa. 1998); (2) Are involuntary commitment proceedings under Article III of the MHPA procedurally analogous to criminal prosecutions? In re: J.M., 762 A.2d 1041 (Pa. 1999); (3) Do county mental health/mental retardation administrators have standing to appeal denials of commitment petitions? In re: T.L., A.2d (Pa. Sept. 29, 1999).

Emerich

In Emerich, the Supreme Court answered affirmatively a question that Pennsylvania mental health professionals had been asking for over two decades: do psychotherapists in Pennsylvania have a duty to breach confidentiality to protect third parties similar to the duty psychotherapists in California have had since 1976? See Tarasoff v. Board of Regents of the University of California, 551 P.2d

continued on Page 2
The Reasonable Person Test for Clients

Representing unreasonable clients is always difficult. Representing unreasonable healthcare practitioners has its own unique pitfalls. Many providers are very demanding. Some are used to handing out orders like prescriptions and expect that they will be followed no matter how difficult or unreasonable. Some carry the longstanding feud between the medical and legal professions into their personal relationship.

Moreover we can become “enablers” by not putting our foot down when the bad behavior starts. Out of a fear of failure or hunger we can make our lives miserable by allowing 1% of our clients to take up 50% of our energy. When law schools teach professional responsibility they should perhaps spend more time dealing with practical realities of difficult relationships.

Firing a client who has become too much to take or makes unreasonable demands is hard but it can be like having an enormous weight lifted off our shoulders. Not only will it make our lives easier on a personal basis but, it will in its individual way, send a message that the legal profession does have some standards of decorum and expects them of clients in a professional relationship.

When a decision has been made tell the client firmly. Give him his file, get a receipt, and move on. Breaking up may be hard to do but it may be the best way to preserve our sanity and help our profession.

Last Chance for Nominations for Second Annual Excellence in Healthcare Law Award

Nominations for the second Annual Excellence in Health Care Law Award are open only until Jan. 15th. Candidates should represent the highest ideals of our profession in the practice of health care law. Nomination letters should be sent to PBA, Paula G. Sanders, Chair, Health Care Law Committee, P.O. Box 186, Harrisburg, PA 17108.

Join the ABA’s Health Law Section

The American Bar Association’s Health Law Section provides members many benefits. In addition to ten Interest Groups, the Section provides many CLE opportunities and publications. Its flagship publication, The Health Lawyer, is published six times a year. With topics ranging from proposed rule changes to effects of technology on health law to analyses of legislation, to mergers, this publication is one of the most valued benefits of membership. For more information, visit the Section’s Website at www.abanet.org/health or contact Lisa Alicea at (312) 988-5532.
In the 1990’s, many physicians decided to become employees of large institutions, such as hospitals, health systems, physician practice management companies (PPMCs) and HMOs. Many physicians sold their practices to their new employers as part of the process, drawn by attractive buyouts, generous guaranteed salaries and bonuses, leverage with payers, the perceived security of being part of a larger organization, expected reduced overhead through economies of scale, and access to capital, information system technology and practice management expertise.

In reality, large employers now realize that running physician practices is unfortunately not as simple or as financially lucrative as expected. Consequently, some PPCMs and hospitals have declared bankruptcy. Others have decided to unload the physician practices they acquired, to downsize and reorganize their current structures, or to attempt to terminate employment contracts for various reasons (concerns about physician’s performance, economics, personality issues, etc.). Physician employees are therefore faced with unemployment, decreased salaries, changing work environments, and/or renegotiation of their employment agreement terms.

Additionally, many physicians have concluded that employment by a large employer is not at all what they expected or now want. Because most employment scenarios do not involve equity participation in the practice (in contrast to small practice relationships where physicians usually do have an ownership interest), the physicians are truly employees with little autonomy or control. They are therefore subject to consequences which they would not (or did not) encounter in physician-owned practices. For example, they are subject to periodic personnel reviews; someone is keeping a personnel file on them; business people are letting them know how productive or nonproductive they are; their bonuses are tied to circumstances (i.e., overhead, billing practices) frequently beyond their control; the employer may be monitoring their charts and records; the employer may or may not be providing the physician with all that he or she believes is necessary to properly function in the practice; the employer may unilaterally require them to work at a different geographic location; and/or the physician may have little or no input into what is going on, from a management standpoint. Dissatisfied with these issues, some physicians are considering alternatives to their current employment situations.

What new employment options do terminated or dissatisfied physicians have? Their present contractual terms play a big role in the process. However, among possible options, they may: (1) buy their practices back and practice independently; (2) join a physician-owned practice; (3) start a solo or group practice or (4) join a different large employer with whom they are better suited.

Several common issues exist for new employment scenarios. First, the employment agreement must be carefully reviewed for provisions addressing the effects of termination, such as non-solicitation of patients, non-hiring of employees, restrictive covenant limiting where the physician may work and for how long, or restrictions on the physician’s contracting with particular entities such as HMOs, PPOs, IPA’s, competitors, etc. The restrictive covenant provisions may have dramatic impact, so it is important to identify exactly when it does or does not apply (e.g., if employer terminates for cause or not for cause; if physician terminates for cause or not for cause; is it enforceable even if the employer will not renew the contract on substantially similar terms, etc.). Second, terminated physicians should be aware of post-employment ramifications of termination, which include difficulty in getting on another medical staff; retaining staff privileges or getting managed care business; data bank reporting; and harm to the physician’s professional and/or personal reputation.

The physician may buy his or her practice back. The physician may negotiate to have the employer pay the physician to get out of the deal. Legal and practical considerations for physicians buying their practices back, or starting or joining independent practices, include legal and tax aspects of the purchase/buy-in; choice of entity (sole proprietorship, professional corporation, LLC, LLP); entity formation documents and related contracts (employment agreements, buy-sell agreements, etc.); office staff; computer systems; location and lease; payer arrangements; patient charts; tax ID numbers; phone numbers; advertising, etc. Some of these aspects may be addressed in negotiations with the former employer, who may or may not be cooperative in facilitating the transition.

Alternatively, a physician may decide to stay with the large employer and renegotiate his or her employment agreement when the initial term expires. Renegotiating tips include:

Evaluate the employer’s history and anticipated future direction. How do they compare to the “competition?”

continued on Page 4
Disintegration of Medicine
continued from Page Three

What are they looking for in continuing to employ the physician and why? What is the physician looking for?

What changes to the relationship are they proposing (e.g., compensation, hours, location, scheduling, coverage, etc.)?

Why is the physician interested in continuing to be employed by them? Why would the physician not be interested (e.g., if compensation arrangement won’t be as good, unhappy with management, etc., would the physician like to take the practice back instead)?

What is the best case scenario? What must the physician have (the bottom line) and what is the physician willing to concede/trade off for something else?

What is the employer’s history with physicians? Why have physicians left the practice/employer?

What are the employer’s reasons for negotiating/renegotiating this contract?

How viable are the employer and “this practice” economically? Is the practice running efficiently?

If a proposed compensation change is unacceptable to the physician, physician and employer may negotiate a “buy-out” of the existing contract terms in exchange for the compensation reduction.

Carefully scrutinize the grounds for termination for cause by employer and limit them as much as possible (e.g., final termination of hospital privileges, not merely a suspension of hospital privileges) and make sure there is an opportunity to cure.

Physicians now face employment and practice options with a different expectation and outlook than they did five years ago. Counsel should assist them in collecting information about themselves and their employment situations and opportunities in order to best plan for and negotiate their future employment.

Medicaid Voluntary Disclosures and Proactive Audits

The Pennsylvania Department of Public Welfare is undertaking an initiative on voluntary disclosure and proactive audits which is intended to update its current proactive audit protocol and encourage providers to disclose overpayments.

This program has been utilized by the Department and provider community as a mechanism for reporting overpayments under the Medical Assistance Program. Recently the Office of Inspector General of the Department of Health and Human Services announced a new provider self disclosure protocol. (Federal Register Volume 63, No. 210, Oct. 30, 1999). The OIG, like DPW, has for years encouraged self reporting to resolve billing and related problems. DPW says it wants to continue encouraging the health care industry to conduct voluntary self evaluation and provide the opportunity for self disclosure. DPW has begun working with health care stakeholders to refine its protocol and has already begun meetings with interested parties.

Fortuna Kostelac, Acting Director of the state’s Bureau of Program Integrity said: “The purpose of the protocol is to establish uniform means of disclosure without requiring prior consultation with DPW. The starting point for any refinement to DPW’s protocol will be the OIG protocol with any changes intended to accomplish twin goals: availability and reliability.” For questions or comments Fortuna Kostelac may be reached at (717) 772-4602.

Please Join Us for the Health Law Fraud and Abuse Conference on Wednesday, Dec. 1, 1999, at the PBI Conference Center in Mechanicsburg

Fraud and abuse continue to be one of the hottest topics in health law. This first ever PBI Fraud and Abuse Conference, co-sponsored by the Fraud and Abuse Subcommittee of the PBA Health Care Law Committee, addresses fraud and abuse issues on both a state and national level. You will get an update on Capitol Hill happenings, (Will Stark get clipped?), the news from Harrisburg, a “how to” on repairing gainsharing arrangements, sessions on Long-Term Care and more. In addition, a special two-hour “Transactional Clinic” will be a conference highlight. You will work through specific fraud and abuse questions with your peers and the experts. (This type of “hands on” clinic is not offered at larger, national conferences.) Set aside Dec. 1 now so that you can join us. Registration begins at 8:00. The conference is from 8:30 a.m. to 3:10 p.m. The Conference Center is located at 5080 Ritter Rd., Mechanicsburg, PA 17055.
Food Service East, Inc., 582 A.2d 1342 (Pa. 1990), the Supreme Court directly confronted another question only obliquely addressed before in the Commonwealth: are involuntary commitment proceedings under Article III of the MHPA analogous to criminal proceedings? Here, the Court unanimously said no, holding that MHPA warrants can be issued under more lenient standards than criminal warrants. 762 A.2d at 1046-47.\(^6\)

Prior to J.M., appellate cases had either implicitly adopted or implicitly rejected the criminal analogy, i.e., either implicitly adopting it by holding that the MHPA (like a penal statute, see 1 Pa. C.S. § 1928(b)(1)) must be strictly construed, e.g., Commonwealth v. Hubert, 430 A.2d 1160 (Pa. 1981), or implicitly rejecting it by holding that the literal language of the MHPA should not be followed where doing so would defeat the purpose of the MHPA, e.g., Uram v. Allegheny County, 567 A.2d 753 (Pa. Commw. 1989) (application for warrant can be oral notwithstanding statutory provision that it be written). In J.M., the Supreme Court endorsed the latter approach, both by approving of the “common sense” of Uram, 726 A.2d at 1048, and by espousing the twenty-year-old doctrine of the Supreme Court of the United States that “a civil commitment procedure can in no sense be equated to a criminal prosecution,” 726 A.2d at 1046-47 (citing Addington v. Texas, 441 U.S. 418, 428 (1979)). In light of J.M.’s explicit rejection of the criminal law analogy, the vitality of earlier cases that had adopted a rule of strict construction, e.g., Hubert, 430 A.2d 1160 — a rule implicitly resting on a criminal law analogy, see 1 Pa. C.S. § 1928(b)(1) — is in doubt.

In re: TJ

When county mental health/mental retardation offices petition for civil commitment under the MHPA, and the court denies the petition, can the MH/MR office appeal? The Supreme Court said yes in In re: TJ, 1999 Pa. LEXIS 2900 **8-9. Although this result may seem obvious, Superior Court had held otherwise. 699 A.2d 1311 (Pa. Super. 1997).

The Supreme Court relied primarily on its holding in Pennsylvania Game Commission v. Dept. of Environmental Resources, 555 A.2d 812 (Pa. 1989), that administrative agencies always have standing in matters that affect their statutory responsibilities. County MH/MR offices have broad statutory responsibilities in the field of mental

Mental Health Procedures Act

continued from Page One

334 (Cal. 1976). The first reported case to address the applicability of Tarasoff in Pennsylvania, Hopewell v. Adebimpe, 130 Pitt. L.J. 107 (Allegheny C.P. 1982), expressly rejected it as inconsistent with the MHPA’s confidentiality provisions. Id. at 108-109. Appellate cases subsequently leaned the other way, however. Superior Court implied that such a duty might exist on some facts, e.g., Dunkle v. Food Service East, Inc., 582 A.2d 1342 (Pa. Super. 1990). No reported appellate decision until the Supreme Court’s in Emerich squarely held that Tarasoff is to be followed in Pennsylvania. The Emerich Court summarized its holding:

We find, in accord with Tarasoff, that a mental health professional who determines, or under the standards of the mental health profession, should have determined, that his patient presents a serious danger of violence to another, bears a duty to exercise reasonable care to protect by warning the intended victim against such danger.

* * *

First, the predicate for a duty to warn is the existence of a specific and immediate threat of serious bodily injury that has been communicated to the professional.

* * *

Moreover, the duty to warn will only arise where the threat is made against a specifically identified or readily identifiable victim. 720 A.2d at 1040.\(^3\)

Reaching this conclusion required consideration of two distinct issues: first, the question of any duty to third parties at all; second, the question whether confidentiality statutes block discharge of any such duty here. Having decided in 1990 that physicians have duties of care toward third parties in circumstances of danger to foreseeable victims, Goryeb v. Commonwealth, Department of Public Welfare, 575 A.2d 545 (Pa. 1990), DiMarco v. Lynch Homes, 583 A.2d 422 (Pa. 1990), the Supreme Court in Emerich had only to address the question whether any of several potentially applicable statutory provisions protecting the confidentiality of psychotherapist-patient communication bar psychotherapists from making disclosures necessary to protect third parties. Although the psychotherapist-patient privilege statute, 42 Pa. C.S. § 5944, has no express exception for the protection of third parties, it incorporates by reference rules governing attorney-client privilege, which do contain such an exception. Pa. R.P.C. 1.6(c)(1). Regulations governing licensed psychologists also have such an exception. 49 Pa. Code § 41.61. Similarly, the MHPA’s confidentiality provisions, 50 P.S. § 7111, have no protection exception, but regulations thereunder (arguably) do. 55 Pa. Code § 5100.32(a)(9). The Emerich Court concluded that these exceptions to confidentiality are applicable to credible threats made toward identified or readily identifiable third parties, and thus are not a barrier to discharge of the duty to warn. 720 A.2d at 1042.\(^4\)

The Court noted the possibility that, but did not decide whether, the duty to protect a third party might some-

continued on Page 6
Mental Health Procedures Act
continued from Page Five

health. See, e.g., 50 P.S. § 4301(a). 1999 Pa. LEXIS 2900 *8. One important limitation on the practical consequence of the standing of county MH/MR offices to appeal denials of commitment petitions is the “last 30 days” rule for initial commitment under the MHPA, 50 P.S. § 7301, which requires that the behavior described therein has occurred within 30 days of the commitment. An appeal apparently would not toll the running of the 30 days, so only hyper-expedited appeals would permit the relief sought by petitioner. The Court expressly left open the question whether the trial court could, by supersedeas or otherwise, order detention of the respondent pending appeal from a denied petition. 1999 Pa. LEXIS 2900 *11 n.5.

1The opinions expressed herein are not necessarily those of the Commonwealth, Department of Public Welfare.

2In J.M. and T.J., DPW filed amicus briefs in support of the county appellants.

High Court Supports Healthcare Employer
By Kimberly Thomas, Esquire

Spierling v. First American Home Health Services, Inc., et al., No. 1441, 1999 Pa. Super. LEXIS 2819 (Pa. Super. Sept 1, 1999). In reviewing old and discarded files pursuant to a federal government investigation regarding Medicare fraud, an at-will private sector employee uncovered evidence of suspected past Medicare fraud and notified her supervisor. The supervisor reported it to a corporate officer and to a federal fraud hotline. Three days later, the corporate officer terminated the employment of the employee and her supervisor. The employee alleged wrongful termination after reporting suspected evidence of Medicare fraud, arguing a public policy exception to the at-will employment doctrine. The Pennsylvania Superior Court held that there is no applicable public policy exception to the at-will employment doctrine for reporting of suspected past Medicare fraud, even where a private sector employee is obligated by her employer to report any suspected Medicare fraud, where the employee is under no statutorily imposed duty to report the suspected past Medicare fraud, the employer does not request that the employee commit a crime, and there is no specific statutory prohibition against the employee’s discharge.

National Summit of State Mental Health Directors

On Sept. 13-16, 1999 at the National Summit of State Mental Health Directors, held in Washington, D.C., the use of seclusion and restraints was the hot topic. Mental health facilities throughout the country have been, both for clinical and legal reasons over the last several years, striving to limit the use of seclusion and restraints. This is often a daunting task given the requirement to treat persons in the least restrictive way without using more drug therapy than necessary.

Of the 168 hospitals represented, a Pennsylvania hospital was recognized as the only one which had entirely eliminated the use of seclusion. Allentown State Hospital, operated by the Pennsylvania Department of Public Welfare, received accolades for achieving this remarkable goal. Acting Chief Executive Officer Richard O’Dea said, “the joint efforts of the medical staff with direct care and supervisory employees in providing personal attention to the needs of each patient was what made this possible. The staff emphasized the dignity and respect owed to each individual.” An award will be presented to the staff of Allentown State Hospital on Nov. 19th at a ceremony marking the first anniversary of the elimination of the use of seclusion at the hospital.
Since the last update, the following bills have been introduced by the Pennsylvania legislature:

Three bills have been introduced to allow health care providers to jointly negotiate with health plans. On July 23, **SB 1052** was introduced. On Aug. 30, **HB 1818**, the Health Care Provider Joint Negotiation Act was introduced. Unlike SB 1052, HB 1818 prohibits joint coordination by health care providers of strikes and job actions. Both HB 1818 and SB 1052 allow independent providers to negotiate non-fee-related contract terms with insurers. Also on Aug. 30, the Physician Collective Negotiation Act, **HB 1816**, was introduced. This bill would preclude joint negotiation over certain fee and compensation-related terms unless the managed care organization expressly requested such negotiation.

**HB 1799** was introduced on Aug. 11, 1999 and was referred to the Committee on Insurance. This bill provides for definitions relating to quality health care accountability and protection, managed care organization duties regarding continuity of care, required disclosures, internal complaint process, and appeals.

On Aug. 30, 1999, **HB 1808** was introduced. This comprehensive bill would regulate the practice of naturopathy and the right to practice medically related acts and would establish a State Board for licensing and certification.

In September, the House Insurance Committee held public hearing regarding life insurance viatical settlements (**HB 1127**). The Insurance Department, the Insurance Federation of Pennsylvania and the Viatical Association of America all expressed support for viatical industry regulation.

**SB 1065** would provide for single recovery in tort actions by abolishing the collateral source rule and the right of subrogation. This was referred to the Judiciary Committee.

On Oct. 18, 1999, **HB 1966** was introduced and referred to the Committee on Insurance. This bill would provide for health insurance policy disclosures.

**HB 1959**, introduced by Rep. Orie on Oct. 18, 1999, would provide for the screening of patients for symptoms of domestic violence and would provide training for health care workers.

**HB 1965**, introduced on Oct. 18, 1999, joins the numerous other pieces of legislation that have been introduced at both the state and federal level to address medical record confidentiality.
On Nov. 30, 1999, the Managed Care Subcommittee will present a Lunch and Learn Program in Philadelphia titled the “Changing Liability Landscape for Managed Care.” Serving as faculty for the program were Ernest L. Tsoules, Esq., Joshua M. Spielberg, Esq. and Brad X. Terry, Esq. The program will center on current and emerging theories of managed care liability exposure in the areas of fraud and abuse in a capitated system under Medicare, the current state of ERISA preemption, and new theories which circumvent ERISA preemption, especially RICO class action suits.

The subcommittee would like to continue to present timely programs in the future, and welcomes suggested topics. Suggestions can be directed to Renee Martin, at my e-mail address: rhmartin@rssm.com or by calling me at (215)-851-8107.