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Health Law Update

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"The Sooner the Better" Is Not Enough to Prove Causation

The Maine Supreme Judicial Court, sitting as the Law Court, recently decided *Holmes v. Eastern Maine Medical Center,* 2019 ME 84, 208 A.3d 792. In *Holmes*, the Court affirmed judgments in favor of three defendants: Eastern Maine Medical Center (EMMC), a surgeon employed by the hospital, and a radiologist employed by a separate entity. The Superior Court entered summary judgment in favor of the radiologist, who was represented by Mark Lavoie and J.D. Hadiaris of NH&D. Because the other defendants' motions for summary judgment had been denied, the case went to trial before a jury, which returned verdicts in their favor. The Law Court decision, which focused on the claim against the radiologist, is significant because of what the Court had to say about a malpractice plaintiff's need to prove that a causal connection actually exists between a defendant's alleged negligence and specific, identifiable harm suffered by the patient. Michael Holmes underwent colon surgery at EMMC on August 14, 2012. On August 20th, he returned to the EMMC emergency department complaining of abdominal pain. The covering surgeon promptly ordered a CT scan. The scan was first read that evening by a "nighthawk" radiologist, and then read again the following morning (the 21st) by the defendant-radiologist. Neither radiologist interpreted the scan as showing evidence of an anastomotic leak — that is, a condition in which bowel contents leak into the abdomen at the junction of the two parts of the bowel that were surgically reconnected after the earlier surgery. The patient was thought to have an ileus, a condition in which the intestinal track "slows down," and so he was monitored with the expectation that he would recover bowel function Over the course of the day on August 21st, however, Mr. Holmes' condition got worse. The severity of his condition was recognized that evening — about 14 hours after the defendant-radiologist's reading of the CT scan — and exploratory surgery was performed. In the course of that second surgery an anastomotic leak was detected and repaired. The leak had allowed bowel contents to enter Mr. Holmes' abdomen, causing a severe systemic infection. He remained in the hospital, gravely ill, for several weeks, suffered a stroke while hospitalized, and was left with serious deficits. The plaintiff presented an expert who testified at deposition that the defendant-radiologist, reading the CT scan at 8:00 a.m. on August 21st, had negligently failed to diagnose an anastomotic leak. The key issue at the summary judgment stage was whether, assuming the leak was present and diagnosable at that time, its consequences had already become unavoidable. The radiologist pointed to testimony by the Plaintiffs' own experts, who said that the most serious sequelae of the leak — the systemic infection and the stroke — could have been avoided only if the leak had been detected and repaired on the evening of August 20th, roughly 10 hours before the defendant-radiologist read the CT scan. The Plaintiffs, on the other hand, pointed to testimony from one of their experts, who said that Mr. Holmes could have avoided *some* harm even if diagnosis and intervention had occurred on the morning of the 21st. His opinions, however, were vague at best. The expert testified that it is generally better to treat infections earlier than later, because every minute that passes with an untreated infection causes the patient to suffer "physiologic hits." His testimony, as characterized by the Plaintiffs, was that surgery performed earlier "would have had some benefit in terms of improving the potential for a better outcome" — essentially, "the sooner the better." The Superior Court judge ruled, and the Law Court agreed, that this testimony was insufficient to get the plaintiffs' case to a jury. Notably, the Law Court cited cases from other jurisdictions which have held that it is not enough for an expert to say that "time is of the essence," or that "every

hour counts." Rather, there must be evidence sufficient to enable a jury to find that a defendant's negligence more likely than not caused some specific, identifiable injury. Because no expert could say that intervention on the morning of August 21st probably would have averted any particular injury to Mr. Holmes, the judgment was affirmed.

Reasoned Medical Decisions Do Not Amount to "Disability Discrimination"

In *Cutting v. Down E. Orthopedic Assocs., P.A.,* 2019 WL 1960329 (D. Me. 2019), the United States District Court for the District of Maine addressed a question that has not received much attention: when a physician's decision whether to treat a patient is influenced by the existence of a disability, can that decision ever be characterized as "disability discrimination" under the Americans with Disabilities Act (ADA) and the Maine Human Rights Act (MHRA)? In the *Cutting* case, which NH&D defended, the District Court explained the limited circumstances under which liability can be imposed on treating physicians for disability discrimination, and entered summary judgment against the plaintiff because the evidence was insufficient to bring her claim within the reach of the ADA or the MHRA. The plaintiff in the *Cutting* case suffered from Tourette's syndrome, which caused her to have repeated involuntary body movements, including repetitive shoulder flexion of the right arm in an outward motion, which her medical records described as resembling a "punching motion." The frequency and severity of plaintiff's tics depended on factors which included her stress level, and whether she was comfortable in her surroundings. In 2013, she was referred to an orthopedic surgeon for long-standing, persistent right shoulder pain. The surgeon examined the shoulder and diagnosed the plaintiff as suffering from acromioclavicular arthritis with possible rotator cuff tendonitis and impingement, and recommended surgery. While waiting to decide whether to proceed with surgery, the plaintiff saw other providers. One doctor told her that he questioned whether she would be able to limit the motion of her right arm enough to heal post-surgically. Eventually, however, the plaintiff did decide to undergo surgery. The surgeon performed an open distal clavicle excision – the removal of part of the distal clavicle and arthroscopy. During the arthroscopic portion of the procedure, he identified both a partial thickness rotator cuff tear and a full thickness rotator cuff tear. He debrided and smoothed the rough edges around the tears, but chose not to attempt a rotator cuff repair because he believed the plaintiff would re-tear the tendon following surgery when she experienced movements caused by her Tourette's syndrome. The plaintiff later sued, contending she was afforded services "on the basis of disability" that were "not equal to that afforded to other individuals," in violation of the ADA and MHRA. Although she alleged various subsidiary acts of discrimination, the essence of the lawsuit was her dissatisfaction with the surgeon's decision not to repair her rotator cuff tear when he discovered it during surgery, because he believed her tics would disrupt the repair. In essence, she claimed that her rights were violated because she was denied the benefit of a procedure the surgeon would have performed on a person who did not have her disabling condition. The Court rejected that claim, reasoning that it was one of "medical malpractice, not discrimination," and that "[s]pecific medical decisions, which must account for a patient's conditions and traits to meet the professional standard of care, generally do not constitute unequal service delivery 'on the basis of disability' within the meaning of the ADA." The Court went on to explain:

Ultimately, medical care decisions can only be challenged "by showing the decision to be devoid of any reasonable medical support."

[T]he point of considering a medical decision's reasonableness in this context is to determine whether the decision was unreasonable *in a way that reveals it to be discriminatory.* In other words, a plaintiff's showing of medical unreasonableness must be framed within some larger theory of disability discrimination. For example, a plaintiff may

argue that her physician's decision was so unreasonable – in the sense of being arbitrary and capricious – as to imply that it was pretext for some discriminatory motive, such as animus, fear, or "apathetic attitudes."

Cutting v. Down E. Orthopedic Assocs., P.A., at *7 (quoting *Lesley v. Hee Man Chie*, 250 F.3d 47, 55 (1st Cir. 2001)). *Cutting* is consistent with a handful of federal decisions which tell us that where medical treatment decisions are concerned, the scope of liability for disability discrimination is quite narrow. There can be liability where the discrimination is obvious and objectively groundless – for example, in the seminal case of *Bragdon v. Abbott*, 524 U.S. 624 (1998), where a dentist simply refused to treat an HIV-positive patient because of unfounded fears about the transmissibility of the virus. As one federal appellate court has said, however, "[w]here the handicapping condition is related to the condition(s) to be treated, it will rarely, if ever, be possible to say with certainty that a particular decision was 'discriminatory.'" *United States v. Univ. Hosp., State Univ. of New York at Stony Brook*, 729 F.2d 144, 157 (2d Cir. 1984).

"Conscience Rule," Enacted by DHS, Is On Hold Pending Appeal

Over the past several decades, Congress and state legislatures have enacted statutes which give employees, both generally and in the health care field specifically, the right to act in ways that are consistent with their religious beliefs. The broadest protection, in the sense that it cuts across all sectors of the economy, is found in Title VII of the Civil Rights Act of 1964. Title VII gives employees the right to accommodations in the workplace when *bona fide* religious practices or beliefs conflict with job requirements, so long as those accommodations do not impose an "undue hardship" on employers. The most common examples of conflict between work and religious observance involve attendance and dress. Where attendance is concerned, the Supreme Court has said that an employer is not required "to bear more than a de minimis cost" in order to accommodate an employee's religious scheduling preference. *Trans World Airlines, Inc. v. Hardison,* 432 U.S. 63, 84 (1977). Under that standard, employers are not required to bear additional costs to give days off based on religion, when they do not bear additional costs to give other employees the days off they prefer, since that "would involve unequal treatment of employees on the basis of their religion." Other, less typical examples of conflict between work and religion, which have also produced Title VII litigation, include:

- A male employee who had a religious objection to working in an area where there were nude pictures of women hanging on the wall, *Lambert v. Condor Mfg., Inc.*, 768 F. Supp. 600 (E.D. Mich. 1991);
- A Roman Catholic surgical aide who refused to clean instruments which were used to perform abortions, *Tramm v. Porter Memorial Hospital,* 1989 U.S. Dist. LEXIS 16391 (N.D. Ind. Dec. 22, 1989);
- An atheist telemarketing employee who objected to interacting on the phone with religious organizations, *McIntyre-Handy v. West Telemarketing Corp.*, 97 F. Supp. 2d 718, 736 (E.D. Va. 2000); and
- A Roman Catholic police officer who objected to being assigned to guard an abortion clinic, *Rodriguez v. City of*

Chicago, 156 F.3d 771 (7th Cir. 1998).

It is in the field of health care, however, that the conflicts have become most pointed. In 1973, shortly after the Supreme Court decided *Roe v. Wade*, Congress passed the "Church Amendment," which prohibits public officials from requiring any person to perform a sterilization procedure or abortion if doing so would be contrary to his or her religious beliefs. Within a decade after *Roe*, at least forty states, including Maine, had enacted statutes allowing health care providers the right to choose not to provide sterilization procedures and abortions. Since then, "conscience protection" has expanded, so that many laws now relieve health-care providers of not only the need to perform procedures they object to, but also the obligation to provide counseling or referral services to patients. In 2019, the United States Department of Health and Human Services (HHS) adopted a rule which, if implemented, would supersede all the conscience protections that currently exist under various federal laws. In support of the rule, HHS asserted that the rule was necessary because there has been confusion about existing conscience protections, and because there has been a "significant increase" in the number of complaints the Department's Office of Civil Rights (OCR) has received about violations of existing laws. The HHS rule broadly prohibits any "health care entity" – including any hospital, pharmacy, medical laboratory, and "other health care provider or health care facility" – from taking adverse action against an employee for refusing to perform or "assist in the performance" of health care activities on account of "religious, moral, ethical or other reasons." The Rule defines the term "assist in the performance" as "tak[ing] an action" with a "specific, reasonable, and articulable connection" to furthering a particular procedure, program or service. Assisting may include "counseling, referral, training, or otherwise making arrangements" for the procedure, program or service at issue. In litigation, HHS has acknowledged that the rule, as drafted, "would authorize individuals at some remove from the operating theater or medical procedure at issue to withhold their services." It "would apply, for example, to a hospital or clinic receptionist responsible for scheduling appointments, and to an elevator operator or ambulance driver responsible for taking a patient to an appointment or procedure." "It would also, for the first time, . . . permit abstention from activities ancillary to a medical procedure, including ones that occur on days other than that of the procedure." Under the Rule, a health care entity's attempts to accommodate an employee's religious or moral objections does not constitute discrimination if the employer offers an "effective accommodation" and the employee "voluntarily accepts" that accommodation. Conversely, if the employee does not consent to the accommodation offered by the employer, the employer must carry out the procedure using "alternate staff or methods" that do not require additional action by the employee, and may not take action which constitutes an "adverse action" against the employee or excludes her from her "field of practice." In a lengthy decision handed down on November 6, 2019, a federal judge in the Southern District of New York prohibited HHS from implementing the rule. *State of New York v. United States Dept. of Health and Human Services,* 2019 WL 5781789 (S.D.N.Y. Nov. 6, 2019). Two weeks later, a federal judge in the Eastern District of Washington largely adopted the New York decision. *Washington v. Azar*, 2019 WL 6219541 (E.D. Wash. Nov. 21, 2019). The decisions rest on several grounds. Although many of the grounds for the decisions are matters of technical administrative law, they also include, more notably, the Courts' view that the Conscience Rule conflicts with Title VII of the Civil Rights Act, and with the Emergency Medical Treatment and Active Labor Act (EMTALA). With respect to Title VII, the judge in the New York case noted that the Conscience Rule "defines 'discrimination' so as not to contain the defense that the accommodation sought by the employee would present an 'undue hardship' to the employer." That is, the Rule would not "protect an employer who, on account of hardship, refuses to accommodate the employee." By way of example, the Court explained that under the Conscience Rule, if a hospital which receives

federal funds offered an employee a transfer from a unit which performs functions the employee objects to (for example, obstetrics), to a unit which does not (such as neonatal care), the transfer would constitute “discrimination” under the Conscience Rule unless the employee agreed to the transfer. In that situation, a health care facility which receives federal funds “could face liability to HHS – including a loss of funding – under the Rule,” even though the transfer would be perfectly reasonable under Title VII. Because HHS does not have the power to make rules which abrogate rights granted by Congress, this conflict with Title VII was fatal to the Conscience Rule. The Court also observed that the Conscience Rule would conflict with EMTALA. Under EMTALA, hospitals that receive federal funds and have emergency departments must provide emergency care to any patient suffering from an emergency medical condition, regardless of the patient’s ability to pay. EMTALA does not include an exception for religious or moral refusals to provide emergency care. However, the Conscience Rule’s definition of “discrimination” could expose a provider (such as a hospital, clinic or ambulance service) to liability for failing to accommodate an employee’s conscience objection in emergency-care situations. The Court therefore reasoned that the Rule is invalid on the additional ground that it would “create, via regulation, a conscience exception to EMTALA’s statutory mandate.” In summary, as matters currently stand the Conscience Rule is unenforceable. That is in part because it deprives health care employers of rights they have under Title VII, and in part because compliance with the Rule would put hospitals at risk of violating EMTALA. Both district court decisions are now on appeal, one to the Second Circuit and one to the Ninth Circuit Court of Appeals. Decisions will likely come down within the next several months. In light of the current social and political climate, though, it is reasonable to expect that the issue is destined for decision by the Supreme Court.