

Client Newsletter

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NLRB Restricts Nurses’ Right to Wear Union-Related Buttons

The National Labor Relations Board (“NLRB”) recently ruled that a hospital has the right to prohibit employees from wearing “RN’s Demand Safe Staffing” buttons in any area of the hospital where they may encounter patients or their family members. *Sacred Heart Medical Center and Washington State Nurses’ Association*, 347 NLRB No. 48 (2006). The NLRB’s decision in this matter expands upon the NLRB’s long-standing position that an employer has a right to restrict the wearing of union-related buttons and other insignia in immediate patient care areas.

In the fall of 2003, Sacred Heart Medical Center (“Medical Center”) in Spokane, Washington and the Washington State Nurses’ Association (“WSNA”) began negotiations to replace an existing collective bargaining agreement that was set to expire in January of 2004. During the course of negotiations, nurses at the Medical Center began to wear buttons that read “RN’s Demand Safe Staffing”. Nurse managers at the Medical Center expressed concerns to the Medical Center’s Human Resources Department regarding the buttons’ impact on patients and their families. The Medical Center subsequently issued a memorandum prohibiting nurses from wearing the “Safe Staffing” buttons in any area of the Medical Center where they may encounter patients or their family members. The memorandum stated that the buttons’ message gave the impression that there was a lack of safe staffing at the Medical Center, which could lead to patients or their family members to fear that the Medical Center was not able to provide adequate care.

The WSNA filed unfair labor practice charges with the NLRB over the Medical Center’s safe staffing button prohibition. The Administrative Law Judge held that the Medical Center had violated the National Labor Relations Act by promulgating, maintaining and enforcing a policy that prohibited its employees from wearing the “Safe Staffing” button outside immediate patient care areas. The Medical Center appealed the Administrative Law Judge’s ruling to the NLRB, which has long recognized that although an employer has a right to restrict union related buttons in immediate patient care areas of health care institutions, such restrictions are presumptively invalid outside of immediate patient care areas. The NLRB has, however, allowed an employer to rebut the

presumption of invalidity by showing “special circumstances” that establish that the restrictions are necessary to avoid disruption in health care operations or disturbance of patients.

In its decision reversing the Administrative Law Judge’s decision, the NLRB concluded that special circumstances justified the Medical Center’s restriction on the “Safe Staffing” button. The NLRB held that a reasonable person would construe the “Safe Staffing” button as a claim that the Medical Center’s staffing levels were unsafe. The NLRB stated that “such a claim is likely to cause unease and worry among patients and their families and disturb the tranquil hospital atmosphere that is necessary for successful patient care.” The NLRB rejected the WSNA’s claim that special circumstances could not be shown in the absence of evidence of actual disturbance of patients. The NLRB held that evidence of actual disturbance is not required when the Medical Center demonstrated special circumstances justifying a ban on the “Safe Staffing” buttons through testimony from its officials that in their opinion such buttons would disturb patients.

The NLRB’s decision is significant in that it demonstrates how a hospital can show “special circumstances” to rebut the presumption of invalidity for restricting the wearing of union-related buttons outside of immediate patient care areas. Furthermore, the NLRB’s decision allows hospitals to demonstrate that a restriction is necessary to avoid disruption of health care operations or disturbance of patients without evidence of actual disturbance of patients. Rather, the hospital need only demonstrate, through testimony from its officials, that in their opinion such union-related buttons would disrupt health care corporations or disturb patients.

CMS Issues Guidance for “Parking” of EMS Patients in Hospitals

On July 13, 2006, the Centers for Medicare and Medicaid Services (“CMS”) issued a letter to its State Survey Agency Directors regarding the practice of the hospitals of “parking” Emergency Medical Services (“EMS”) patients in the Emergency Department and the potential for violating the Emergency Medical Treatment and Labor Act (“EMTALA”). The “parking” of EMS patients refers to the practice of Emergency Department staff refusing to permit EMS staff to give report and transfer patients from ambulance stretchers to hospital beds. As a result, patients end up being left on stretchers for extended periods of time with EMS personnel in attendance. CMS believes that this practice may violate EMTALA.

EMTALA requires a hospital to provide an appropriate medical screening, within the capability of the hospital’s Emergency Department, to any person who comes to a hospital Emergency Department and requests treatment for a medical condition. If the screening reveals an emergency medical condition, the hospital must stabilize the patient or effect an appropriate transfer to another medical facility. The letter from CMS states that when a patient arrives at a hospital via EMS, the hospital must provide a screening examination to determine if a medical condition exists and, if so, provide stabilizing treatment to resolve the patient’s emergency medical condition. The letter from CMS states that it recognizes the enormous strain and crowding many hospital Emergency Departments face every day. However, the failure to provide a medical screening examination or stabilizing treatment to a patient could result in a violation of EMTALA. Furthermore, the letter from CMS states that parking patients in hospitals and refusing to release EMS equipment or personnel “jeopardizes patient health and impacts the ability of EMS personnel to provide emergency services to the rest of the community.”

Senate Finance Committee Asks IRS to Increase Its Scrutiny of Tax-Exempt Hospitals

Senator Charles Grassley of Iowa, who serves as Chairman of the U.S. Senate Finance Committee, recently sent a letter to the Chief Counsel of the Internal Revenue Service (“IRS”) asking the agency to increase its scrutiny of certain tax-exempt entities, including hospitals. The letter is part of an increasing scrutiny by the federal government of the adequacy of the oversight, reporting requirements and overall governance of non-profit and tax-exempt organizations.

In his letter to the IRS, Senator Grassley states that he strongly believes that given the rapidly changing nature of the health care industry, the regulations and guidance with respect to tax-exempt organizations in this industry need to be monitored and updated on a continuing basis. Senator Grassley states that some of the areas in which the IRS should be particularly concerned about include “the definition of charity care, the requisite level of charity care, the definition and level of community benefit, the definition of joint ventures, joint ventures involving non-profit hospitals, the payment of excessive compensation and the use of tax-exempt bond proceeds.” The letter also requests that the IRS provide the Senate Finance Committee with an explanation of the process of requests for, and revocations of, tax-exempt status for hospitals.

It is expected that the Senate Finance Committee will make the above information available to the public once it is received from the IRS.

Fifth Circuit Reverses Tax Court Decision Regarding Intermediate Tax Sanctions

The United States Fifth Circuit Court of Appeals recently reversed a decision of the U.S. Tax Court upholding an assessment of Intermediate Tax Sanctions by the Internal Revenue Service (“IRS”). The case, *Caracci v. Commissioner*, represents the only case to have court-issued opinions with respect to the assessment of Intermediate Tax Sanctions. More importantly, Fifth Circuit’s decision provides tax-exempt organizations with guidance on the valuation analysis necessary for excess benefit transactions.

In 1976, the Caracci family started the Sta-Home Health Agency (“Sta-Home”) to provide home care in a primarily rural part of Mississippi. Sta-Home was a tax-exempt corporation formed under Mississippi. During 1995, a change in the Medicare regulations was proposed to provide for a prospective payment system known as “PPS”. The Caraccis were concerned that the change to PPS would have an impact on the cash flow for Sta-Home. As a result, the Caraccis consulted with an attorney who recommended converting Sta-Home into for-profit corporations. The conversions to non-exempt status would allow Sta-Home to borrow money that lenders were unwilling to provide to exempt entities. The Caraccis were aware that appraisals showed that Sta-Home’s liabilities exceeded the value of its tangible and intangible assets. Therefore, unless they were able to provide more cash and capital, they would likely not be able to continue to operate Sta-Home. As a result, the Caraccis decided to proceed ahead with the transfer of Sta-Home into non-exempt sub-chapter S corporations. The Caracci family was the owner of these non-exempt corporations. As part of the conversion, the exempt Sta-Home corporations transferred their tangible and intangible assets to the for-profit corporations

in exchange for the assumption of, an indemnification against, liabilities. After the conversions, the Sta-Home entities continued to operate as before, providing the same services to the same patients in the same manner.

In 1999, the IRS issued deficiency notices to the Caracci family and the Sta-Home agencies. The IRS determined that the value of the assets transferred to the non-exempt Sta-Home corporations exceeded the value of the liabilities and debts assumed by the for-profit corporations by approximately \$18.5 million. As a result of this valuation analysis, the IRS concluded that the transfer represented an excess benefit transaction in violation of Section 4958 of the Internal Revenue Code. The IRS determined that the excess benefit transaction resulted in excise taxes and penalties of over \$215 million dollars.

Section 4958 of the United States Internal Revenue Code provides for the imposition of Intermediate Sanctions in the event of an “excess benefit transaction” between “applicable tax-exempt organizations” and “disqualified persons”. (The sanctions are considered “intermediate” because they are a mid-point between the IRS maintaining a neutral position toward private inurement and in the alternative, completely revoking organization’s tax-exempt status.) An excess benefit transaction is defined as a transaction in which any economic benefit is provided by an applicable tax-exempt organization to a disqualified person, if the value of the economic benefit provided exceeded the value of the consideration derived for providing the benefit. Applicable tax-exempt organizations are any organization described in Section 501(c)(3) or (c)4 of the Internal Revenue Code. A disqualified person includes: (1) board members; (2) presidents, chief executive officers or chief operating officers; (3) treasurers and chief financial officers; and (4) other individuals who have substantial influence over the affairs of the organization.

The Intermediate Sanctions rules provide for the imposition of a tax of a disqualified person on the excess benefit they received from an excess benefit transaction. The tax is a “two- tier tax” whereby the IRS would initially impose a 25% tax on the excess benefit. If the disqualified person does not immediately return or “correct” the excess benefit to the organization, the individual is subject to a second-tier tax of 200% on the excess benefit. Furthermore, the organization and each individual who approves the excess benefit is subject to a tax of 10% of the excess benefit, to a maximum of \$10,000. Despite the significant penalties associated with the IRS Intermediate Tax Sanctions, the regulations do provide that an excess benefit transaction is entitled to a “rebuttable presumption of reasonableness”, and therefore, not subject to intermediate sanctions if: (1) the transaction was approved in advance by an authorized body of the applicable tax-exempt organization, composed entirely of individuals who do not have a conflict of interest with respect to the transaction; (2) the authorized body obtained and relied upon appropriate data as to comparability prior to making its determination; and (3) the authorized body adequately documented the basis for its determination concurrently with making that determination.

In *Caracci*, the family filed a Petition in the United States Tax Court challenging the imposition of the excess taxes. The Tax Court upheld the assessment of the excise taxes. However, the Tax Court disagreed with the valuation by the IRS that the value of the assets transferred through non-exempt Sta-Home corporations exceeded the value of the liabilities and debts assumed by approximately \$18.5 million. Instead, the Tax Court conducted their own valuation indicating that the value of the assets transferred exceeded the value of the liabilities and debts assumed by only \$5.1 million. As a result, the Tax Court ordered the Caraccis to pay approximately \$70 million in excise taxes.

The Caraccis appealed the Tax Court’s imposition of excise taxes to the Fifth Circuit Court of Appeals. The Fifth Circuit Court of Appeals reversed the Tax Court’s upholding of an assessment of excise taxes by the IRS. The Fifth Circuit found several errors by the Tax Court. First, the Court noted that the IRS issued its deficiency notices to the Caraccis prematurely on an incomplete analysis of the transaction. During opening

statements in front of the Tax Court, the IRS acknowledged that the deficiency notices were excessive and erroneous. At this point, the Fifth Circuit held that once the IRS made this acknowledgement, the burden shifts to the government to prove the correct amount of any taxes owed. However, the Tax Court did not shift the burden to the government. Instead, Tax Court rejected the testimony of the IRS' valuation expert. The Fifth Circuit held that at this point the IRS failed to meet its burden of proof and the IRS should have found in the taxpayer's favor. However, the Tax Court went forward and conducted its own valuation for the imposition of excise taxes on the Caraccis. The Fifth Circuit found numerous errors in the valuation method used by the Tax Court. For example, despite the fact that Sta-Home had millions in debts and liabilities and operated at a loss for years, the Tax Court used an invested-capital valuation method that compared the Sta-Home entities with solvent, publicly traded companies with significant equity and a present ability to generate profits. Furthermore, the Tax Court's mistaken belief that Sta-Home's intangible assets had substantial fair market value led it to ignore its own "long recognized position that unprofitable, intangible assets do not contribute to fair market value unless those assets produce a net income or earnings." Thus, the Appeals Court reversed the Tax Court's decision and entered judgment in favor of the Caraccis.

The decision by the Fifth Circuit in *Caracci* is significant in that it represents the only decision by a Court (other than by the Tax Court in this case) in regard to the imposition of Intermediate Tax Sanctions. More importantly, the Fifth Circuit's decision emphasizes the importance for tax-exempt health organizations to carefully document fair market value in all transactions with disqualified persons.

Physicians Denied HCQIA Immunity

A recent decision by the North District Federal Court of Texas in the matter of *Poliner v. Texas Health Systems*, 2006 WL 42770425, has gained the attention of those who practice in the health law field. The case concerns a physician whose privileges at a hospital were summarily suspended. He brought suit against the hospital and three individuals who were involved in his suspension through the peer review process. The jury returned a verdict in favor of the physician in the amount of \$366 million. The defendant physicians filed a post-verdict motion claiming that they were entitled to immunity under the Health Care Quality and Improvement Act ("HCQIA"). In order to qualify for HCQIA immunity, a professional review action must be taken:

- (1) in the reasonable belief that the action was in the furtherance of quality health care;
- (2) after reasonable effort to obtain the facts in the matter;
- (3) after adequate notice and hearing procedures are afforded to the physician involved, or after such other procedures as are fair to the physician under the circumstances; and,
- (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

The North District Federal Court of Texas found that the following facts defeated HCQIA immunity for the defendant physicians: the hospital threatened immediate termination of all of the physician's privileges if he didn't agree to an abeyance of Cath Lab privileges; the physician was told that he could not consult an attorney; the physician was not given notice of specific cases or a chance to discuss them prior to abeyance; evidence supported findings that the physician was forced to agree to abeyance under duress; and the hospital's medical staff bylaws require "present danger" to summarily suspend, but the defendant physicians were not certain that present danger existed at the time they demanded the physician's abeyance.

The Court's decision in *Poliner* underscores the importance for health care professionals to comply with the HCQIA's requirements for immunity when undertaking a professional review action.

JCAHO Issues 2007 National Patient Safety Goals

The Joint Commission on Accreditation of Health Care Organizations ("JCAHO") recently issued its 2007 National Patient Safety Goals ("NPSGs"). According to Dennis O'Leary, M.D., President of JCAHO, the NPSGs target critical areas where patient safety can be improved through specific actions in health care organizations. The following is a list of the new goals and requirements listed in the NPSGs, which pertain to hospitals:

- Requirement 8B: A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from a facility.

- Goal 13: Encourage patients' active involvement in their own care as a patient safety strategy.

- Requirement 13A: Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.

- Goal 15: The organization identifies safety risks inherent in its patient population.

- Requirement 15A: The organization identifies patients at risk for suicide (applicable to psychiatric hospitals and patients being treated for emotional and behavioral disorders in general hospitals).

The compliance with the NPSGs and its related requirements is a condition of continuing accreditation or certification for JCAHO accredited hospitals.

SJC Rules Medical Malpractice Expert Should Not Have Been Sanctioned

On July 11, 2006, the Massachusetts Supreme Judicial Court (“SJC”) reversed the decision of a Superior Court judge who ordered a new trial in the wrongful death action of *Wojcicki v. Caragher, M.D.*, after determining that an expert who testified on behalf of the physician defendant gave false and misleading testimony under oath. The SJC held that the expert’s testimony did not constitute fraud in the Court, and therefore, there was no basis to sanction the expert. Furthermore, the Court ruled that there was no basis for the Superior Court judge to award a new trial to the plaintiff.

The plaintiff filed a wrongful death action against Dr. Joan E. Caragher, alleging negligence in the care she rendered to Sherry Wojcicki on July 2, 1999, when Ms. Wojcicki was brought to the Emergency Room of Addison Gilbert Hospital after suffering a severe stroke. Ms. Wojcicki had a recurrence of breast cancer in 1999, for which she received two courses of chemotherapy. The final dose of chemotherapy was administered on July 1, 1999, the day before she was brought to the Emergency Room. The plaintiff alleges that Dr. Caragher had departed from the applicable standard of care for physicians practicing the specialty of Emergency Medicine when she failed either to offer thrombolytic therapy (“t-PA”) to Ms. Wojcicki or promptly transfer her to another hospital where she could receive such therapy. At trial, the plaintiff relied heavily upon an article entitled “Tissue Plasminogen Activator for Acute Ischemic Stroke”, published in the *New England Journal of Medicine* on December 14, 1995. The article reported results of a study consisting of two trials conducted at various medical centers throughout the country by the National Institute of Neurological Disorders and Strokes (“NINDS Study”). The NINDS Study revealed that many neurologists felt that the administration of t-PA to victims of severe stroke within three hours of the onset of stroke, decreased the impairment caused by the stroke.

At trial, Counsel for Dr. Caragher called Dr. Fred Hochberg as an expert witness. Dr. Hochberg is a neuro-oncologist at Massachusetts General Hospital. Dr. Hochberg testified that none of the patients involved in the NINDS Study had cancer. Such testimony supports Dr. Caragher’s decision to refrain from treating Ms. Wojcicki with t-PA. However, the plaintiff’s expert, Dr. Guy Rordorf, a neurologist and stroke specialist at Massachusetts General Hospital, testified at trial that there was no published or unpublished data to support Dr. Hochberg’s testimony that no cancer patients were included in the NINDS Study. Despite this testimony from Dr. Rordorf, the jury returned a verdict in favor of Dr. Caragher.

Counsel for the plaintiff filed a Motion for a new trial in which he alleged that Dr. Hochberg had presented false and perjurious testimony in regarding to the NINDS Study. Specifically, the Motion alleged that Dr. Hochberg falsely testified that no cancer patients had participated in the NINDS Study. In support of the Motion, the plaintiff submitted affidavits of Dr. John Marler, the NIH coordinator for the Study and Dr. Barbara C. Tilley, the lead biostatistician for the Study. Both Dr. Marler and Dr. Tilley confirmed that fifty-nine patients included in the Study had responded positively to a questionnaire regarding whether or not they had been diagnosed as having a malignancy.

After the hearing regarding the plaintiff’s Motion for a new trial, Superior Court Judge Diane Kottmyer, ordered that Dr. Hochberg appear for a deposition and testify as to the basis for his trial testimony. At his deposition, Dr. Hochberg defended his trial testimony and stated that to the best of his knowledge no active cancer patients had been included in the NINDS Study. Dr. Hochberg stated that his testimony in this regard was based upon a telephone conversation he had with Dr. Tilley, the NINDS Study biostatistician, which occurred approximately two weeks before the trial. Counsel for the plaintiff subsequently requested that Dr. Hochberg produce telephone records in support of his testimony regarding his telephone conversation with Dr.

Tilley. The telephone records which were produced by Dr. Hochberg, however, reflect only a thirty second phone call with Dr. Tilley's office in Charleston, South Carolina, on the first day of the trial. Counsel for the plaintiff subsequently produced an affidavit of Dr. Tilley in which she stated that she had never before spoken with Dr. Hochberg. Furthermore, Dr. Hochberg stated that on November 17, 2003, she was in San Francisco attending a meeting of the American Public Health Association.

After reviewing all of the evidence regarding Dr. Hochberg's testimony, Judge Kottmyer ordered a new trial and sanctioned both the defendant and Dr. Hochberg. Judge Kottmyer stated that she found "clear and convincing evidence" that Dr. Fred Hochberg, an expert witness called by the defendant: "(1) intentionally testified at the trial of this case as to the existence of a fact when he did not know whether the fact was true; (2) deliberately misled the Court and the jury as to whether he had reviewed the Study data; and (3) testified falsely at deposition that he had a telephone conversation with Dr. Tilley and that she provided the information on which his trial testimony was based." The Court ordered Dr. Hochberg to pay plaintiff's attorney's fees in the amount of \$17,355, and an additional \$2,585 to the Commonwealth to cover the costs associated with seating a second jury. Judge Kottmyer also sanctioned the defendant, Dr. Caragher, and ordered her to pay attorneys' fees and expenses of the plaintiff in the amount of \$68,000 for baseless and misleading testimony which was presented to the jury on her behalf.

Dr. Caragher appealed Judge Kottmyer's ruling and was granted Direct Appellate Review by the SJC. On appeal, the SJC ruled that Dr. Hochberg's testimony did not constitute "fraud on the court". The Court held that fraud on the court occurs where it can be demonstrated, clearly and convincingly, that a party has sentiently set in motion some unconscionable scheme calculated to interfere with the judicial system's inability impartially to adjudicate a matter by improperly influencing the trier or unfairly hampering the presentation of the opposing party's claim of defense. The SJC held that although aspects of Dr. Hochberg's testimony were "disturbing", it does not support a finding that Dr. Hochberg committed fraud on the court. Specifically, the SJC found that there was no evidence that the judicial process itself was corrupted as a result of Dr. Hochberg's testimony. The SJC concluded that although Dr. Hochberg's testimony was "misleading", it was not clear whether, and to what extent, the Judge Kottmyer found that Dr. Hochberg's testimony was false.

The SJC further held that even if Dr. Hochberg's testimony was false, in order to award a new trial, the plaintiff must demonstrate that the evidence presented in his Motion for a new trial was newly discovered. According to the SJC, evidence is considered "newly discovered" in this context only if it was "unknown and unavailable at the time of trial despite the diligence of the moving party." The SJC noted that the data from the NINDS Study cannot be considered newly discovered because the plaintiff should have anticipated that Dr. Caragher would dispute the Study's application to cancer patients, and could have obtained the data before or during trial. The SJC stated that the plaintiff did not take any action regarding Dr. Hochberg's testimony until after the jury returned an unfavorable verdict, when the plaintiff's Counsel contacted his own expert to discuss his concerns about Dr. Hochberg's testimony.

The SJC reversed the Superior Court's decision allowing for a new trial and vacated the Order imposing sanctions against Dr. Hochberg and the defendant. The SJC held that as no new trial is required, there is no need to compensate the plaintiff for costs associated with a second trial.

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