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In The News

Patient files $14 million lawsuit against VA hospital

The United States is the defendant in a lawsuit alleging substandard care at a Veteran's Administration hospital caused a patient's quadriplegia.

Steven Lewis was treated at the VA Medical Center in Northport, N.Y., from May 2008 through September 2009, after first experiencing left-side weakness and coordination and balance problems.

The lawsuit alleges Lewis was seen by numerous doctors over the course of several months who failed to properly diagnose his worsening condition and failed to refer him to a neurosurgeon. Lewis was ultimately discovered to have a spinal tumor and alleges the hospital's negligence and complications arising from surgery rendered him a quadriplegic. Lewis' lawsuit seeks $14 million in damages in compensation for his severe and permanent injuries.

Lewis v. United States, No. 11-6059 (E.D.N.Y. *complaint filed* Dec. 13, 2011)

Malpractice lawsuit claims hospital released patient in unstable condition

The family of a man who died in 2009 has filed a lawsuit alleging malpractice on the part of a New York hospital.

According to the lawsuit, Joseph Messeroux went to Maimonides Medical Center in October 2009 with complaints of cough, chills and chest pain. He was admitted with a diagnosis of uncontrolled hypertension and elevation in cardiac enzymes.

The lawsuit alleges that, even though his condition was not stable, the hospital released Messeroux to go home. Messeroux later returned to Maimonides and was discharged again. He died on Nov. 1, 2009 after suffering from a cerebrovascular stroke. The lawsuit seeks compensatory and punitive damages in addition to attorney fees.

Messeroux v. Maimonides Med. Ctr., No. 11-5343 (E.D.N.Y. *complaint filed* Nov. 1, 2011)

In The News 1
New York Cases 1
In The U.S. Supreme Court 5
In The Law Journals 7

New York Cases

Physician and hospital sued after patient commits suicide while in transport to another facility

The New York Supreme Court, Appellate Division, Third Department, affirmed a trial court's judgment in favor of physician and hospital defendants in an action arising from the death by suicide of a mental patient while being transported under the physician's orders.

On Feb. 4, 2005, Kirsten Lorraine Dumas was admitted to Adirondack Medical Center after she attempted to commit suicide. While at the hospital, Dumas made two additional attempts to take her life, and her attending physician, Dr. Edward Frost, determined that her condition required that she be transferred to the mental health unit of Glens Falls Hospital.

Frost signed transfer orders but did not direct that Dumas be placed in restraints while being transported. Although a nurse advised the ambulance attendants of Dumas' suicide attempts, she was secured only with standard safety belts across her waist and ankles. During the transport, Dumas unlocked her safety belts and threw herself out of the rear door of the ambulance, resulting in her death.

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Dumas' surviving spouse, David Dumas, sued Frost, the medical center and other parties. The case against Frost and the Center was tried, resulting in a directed verdict in favor of the defendants. David appealed.

The appellate division concluded that Frost's decision not to impose restraints during Dumas' transport was a matter of professional judgment for which Frost could not be held liable. The record indicated that Dumas had been diagnosed with tachycardia, and had to be intubated to assist her breathing while at the medical center.

The trial record further indicated that the plaintiff's own expert acknowledged that Dumas' medical conditions could be aggravated if she were placed in restraints. Moreover, during the over two-hour transport to the medical center, Dumas had not been restrained, and had been calm and had not made any suicidal gestures.

The court further held that Frost rightfully assumed that the ambulance attendants would closely monitor Dumas, especially given the warnings they had received. Accordingly, the trial court did not err in directing a verdict in favor of Frost and the hospital, and its judgment was affirmed.

Dumas v. Adirondack Med. Ctr., No. 07769 (N.Y. App. Nov. 3, 2011)

Nursing home's bankruptcy does not preclude subsequent license revocation

Affirming the district court's judgment, the Second U.S. Circuit Court of Appeals concluded that a state's approval of a bankrupt nursing home's reorganization plan could not be construed as a representation that the state would not exercise its regulatory authority to revoke the nursing home's operating license during the reorganization period.

Legacy Healthcare L.L.C. operated three nursing homes, including Williamsville Suburban L.L.C. Legacy and its nursing homes (collectively, the debtors) filed for bankruptcy protection. The state of New York participated in the bankruptcy proceeding as a creditor. The bankruptcy court entered an order confirming the debtors' reorganization plan on June 6, 2006. The state had voted in favor of the reorganization plan.

On Nov. 20, 2006, a commission created by the state to review the allocation of healthcare resources in New York recommended closure of Williamsville. The debtors claimed that the state should be equitably estopped from revoking Williamsville's operating license. The bankruptcy court granted summary judgment in favor of the debtors, but the trial court reversed the decision of the bankruptcy court and entered summary judgment for the state.

The Second Circuit agreed that the debtors did not establish estoppel. The state did not engage in conduct that amounted to a false representation. The state's vote in favor of the reorganization plan and its failure to object to the bankruptcy court's confirmation order did not qualify as an implicit representation that the state would not exercise its regulatory authority over Williamsville during the reorganization plan period.

The Second Circuit ruled that the state's participation in the bankruptcy proceeding did not constitute a nine-year waiver of its authority to revoke Williamsville's operating license. Any other result would not comport with case law that recognized a distinction between the government's role as a creditor and its role as a regulator.

In re Legacy Healthcare L.L.C., No. 10-3009 (2d Cir. Nov. 21, 2011) *unpublished*

Learned intermediary doctrine precludes failure to warn claim against drug maker

The U.S. District Court for the Eastern District of New York granted a pharmaceutical manufacturer's motion for summary judgment on a consumer's negligent failure to warn claim. The learned intermedi-

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ary doctrine barred the claim where there was no evidence that additional warnings would have altered the prescribing physician's prescription decision.

Eli Lilly & Co. manufactured and marketed the prescription drug Zyprexa for the treatment of schizophrenia and bipolar disorder. The original 1996 Zyprexa package insert provided information about weight gain-related adverse events resulting from ingestion of the drug. In September 2003, Lilly added FDA-required language to the Zyprexa label warning about the risks of hyperglycemia and diabetes mellitus.

Frederick Greaves was prescribed Zyprexa in 1998 while undergoing inpatient treatment. Dr. Richard Whalen took over Greaves' care in 2004 and continued to prescribe Zyprexa.

In May 2004, February 2005 and March 2006, Whalen discussed with Greaves the potential side effects of Zyprexa and obtained Greaves' consent to continue prescribing the drug. Whalen monitored Greaves' weight and blood glucose levels during the course of treatment.

When Greaves gained weight and experienced higher blood glucose levels, Whalen reduced the dosage of Zyprexa rather than discontinuing it. Whalen believed that the benefits of Zyprexa outweighed its risks.

In November 2006, Greaves was diagnosed with diabetes. He sued Lilly for negligence based on a failure to warn. Greaves' lawsuit was one of approximately 30,000 lawsuits brought by users of Zyprexa against Lilly. Lilly moved for summary judgment on Greaves' claim, asserting the defense of the learned intermediary doctrine.

The district court first determined that the law of Rhode Island applied since Greaves was a resident of Rhode Island and was prescribed Zyprexa there. There was nothing to suggest that the Rhode Island Supreme Court would not adopt the learned intermediary doctrine if faced with the issue. Moreover, Lilly had a right to expect that physicians would carry out their duty to warn of the risks of Zyprexa given the notoriety of the Zyprexa litigation in the medical profession.

The district court concluded that application of the learned intermediary doctrine was appropriate. Whalen testified that he believed his decision to prescribe Zyprexa to Greaves was the proper one, despite the risks. There was no evidence that Whalen would have decided not to prescribe Zyprexa if the warnings accompanying the drug had been different. (For earlier decisions in this case see 16 **NYHLU** 2, June 2009, and 17 **NYHLU** 3, February 2010.)

In re Zyprexa Prods. Liab. Litig., Nos. 04-1596, 09-4970 (E.D.N.Y. Nov. 4, 2011)

Insurers allege medical practice fraudulently obtained $2.6 million

Granting insurer plaintiffs' motion for reconsideration of an order dismissing their claims under the Racketeer Influenced and Corrupt Organizations Act (RICO) against a medical practice and its employees, the U.S. District Court for the Eastern District of New York concluded that it erred in previously finding that the complaint did not adequately allege an enterprise and legally distinct persons.

Government Employees Insurance Co. and its related entities (collectively, GEICO) sued Hollis Medical Care P.C. and several alleged owners and employees of Hollis (collectively, the management defendants). The complaint asserted RICO claims among other claims. GEICO alleged that Hollis fraudulently obtained $2.6 million in no-fault benefits.

According to GEICO, Hollis was nominally owned by a physician but it was actually operated by the management defendants. Neither of the management defendants was a licensed physician. The claims forms submitted to GEICO allegedly misrepresented that Hollis was lawfully licensed and that the services provided to patients were medically necessary and actually performed.

The district court dismissed GEICO's complaint, finding in part that the complaint did not adequately allege a RICO enterprise. GEICO filed a motion for reconsideration of the dismissal of the RICO claims against the management defendants.

The district court granted the motion and reinstated the claims. The U.S. Supreme Court's decision in *Cedric Kushner Promotions Ltd. v. King* made clear that the allegations of the complaint were sufficient to meet the distinctness requirement.

GEICO alleged that Hollis was the "enterprise" and that the management defendants were the "persons" who associated with Hollis and participated in the fraudulent scheme. The district court found that the management defendants were natural persons who were legally distinct from Hollis even though they were all employees of Hollis.

The remaining elements of GEICO's claim were plausibly pled. GEICO claimed that the management defendants participated in the conduct of the alleged enterprise's affairs by making payments to physicians who effectively sold their medical licenses to Hollis.

In exchange for payments from the management defendants, the physicians falsely represented that they were the true owners of Hollis. GEICO also contended that the management defendants submitted or caused to be submitted over 46,000 separate fraudulent claims to it by mail over a six-year period.

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Gov't Employees Ins. Co. v. Hollis Med. Care P.C., No. 10-4341 (E.D.N.Y. Nov. 9, 2011)

Physician's license revoked for submitting claims under other physician's name

The New York Supreme Court, Appellate Division, Third Department, confirmed an administrative determination revoking a physician's license based on the submission of claims to insurers under another physician's name.

Dr. Harry Josifidis was excluded by certain health insurers from being reimbursed as an in-network provider for treatment rendered to their insureds as the result of a prior disciplinary action. Josifidis thereafter entered into an agreement with another physician (hereinafter the other physician) by which the other physician's name appeared on claims submitted to the insurers for Josifidis' treatment of in-network patients.

In February 2010, the New York Bureau of Professional Medical Conduct charged Josifidis with 15 specifications of misconduct. Following a hearing, a hearing committee determined that Josifidis knowingly caused bills to be submitted falsely under another physician's name, and revoked Josifidis' license. Josifidis sought judicial review.

The appellate division concluded that the record contained substantial evidence supporting the hearing committee's determination. Josifidis' contention that he entered into the agreement with the other physician to provide his patients with continuity of care rather than for profit was not relevant to the determination. Under applicable precedent, fraudulent practice need not benefit a physician or injure a patient to constitute misconduct.

Moreover, the agreement at issue explicitly applied not only to patients Josifidis was already treating before he was excluded by the insurers, but also to future patients, and the other physician testified that the number of patients increased during the life of the agreement.

The appellate division separately rejected Josifidis' contention that the penalty imposed was excessive. Under applicable precedent, a hearing committee's penalty will not be disturbed unless it is so incommensurate with the offense as to shock one's sense of fairness. Here, the committee noted Josifidis' history of repeated egregious conduct warranted a severe sanction, and observed that in both of his disciplinary proceedings Josifidis sought to shift blame rather than accept his own responsibility.

The court found the committee's determination that nothing short of revocation would protect the public from the risk of recurrence to be reasonable and not shocking to its sense of fairness. Accordingly, the determination was confirmed.

Josifidis v. Daines, No. 07891 (N.Y. App. Div. Nov. 10, 2011)

Issues exist in medical provider's reimbursement action against insurer

The U.S. District Court for the Southern District of New York ruled that an insurer is not entitled to summary judgment in a medical provider's reimbursement action. Genuine issues of fact existed as to whether the insurer's decision to deny a claim for additional reimbursement was proper and whether administrative remedies were appropriately exhausted.

Biomed Pharmaceutical Inc. was a medical provider that provided care for one of its patient's chronic medical conditions, hemophilia. The patient was a participant in Oxford Health Plan's ERISA governed plan.

At some point, Biomed began to treat the patient on a financial hardship waiver whereby, at various times, the patient did not pay anything. Nonetheless, charges were submitted to Oxford that paid Biomed at various levels for treatment rendered to the patient even under the financial hardship waiver.

After a period of time Oxford took the position that, since the financial hardship waiver had been approved, the plan would not pay anything. Biomed then sued to recover additional reimbursement. Oxford moved for summary judgment arguing its decision to deny Biomed's claim for additional reimbursement was not arbitrary and capricious and that the patient failed to exhaust administrative remedies.

The district court denied Oxford's motion. Oxford failed to demonstrate it was entitled to summary judgment on either of the grounds raised in its motion. Genuine issues of material fact existed with respect to whether Oxford's decision to deny Biomed's claim for additional reimbursement for covered services was arbitrary and capricious and whether administrative remedies were appropriately exhausted.

Biomed Pharms. Inc. v. Oxford Health Plans (N.Y.) Inc., No. 10-7427 (S.D.N.Y. Nov. 15, 2011)

Former hospital employee alleges retaliatory discharge

Granting summary judgment to an employer on discrimination claims, the U.S. District Court for the Southern District of New York held that a former employee did not present evidence of any policy or practice of paying employees holding the same position in a discriminatory fashion.

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On May 19, 2008, Martin Ukeje, a black man, began working for the New York Health and Hospitals Corp. (HHC) at Governeur Hospital as a respiratory therapist. In March or April 2009, Ukeje discovered that a white coworker in the same position was being paid $14,000 more per year. Ukeje claimed that his coworker's pay stub was in open view.

In an email to Lois Penn, HHC's Equal Employment Opportunity Officer, Ukeje stated that he was earning less than a white coworker with the same title, same duties and same qualifications. Ukeje showed a copy of the coworker's pay stub to Penn during a meeting. According to Penn, Ukeje admitted that he made the copy without his coworker's permission. Ukeje denied making that admission.

HHC served Ukeje with disciplinary charges for gross misconduct for making a copy of confidential information without authorization. The labor relations specialist for HHC later determined that Ukeje was not entitled to disciplinary rights and could be terminated at any time during his probationary period. HHC terminated Ukeje effective May 26, 2009.

Ukeje sued HHC alleging violation of 42 U.S.C. § 1983, the New York State Human Rights Law and the New York City Human Rights Law. Ukeje contended that HHC unlawfully fired him in retaliation for his complaints of discrimination.

To hold a municipality liable under § 1983, a plaintiff must establish that the alleged violation of constitutional rights resulted from a municipal policy or custom. The district court concluded that HHC was entitled to summary judgment because Ukeje failed to show the existence of a policy or practice of paying respiratory therapists in a discriminatory manner. Ukeje admitted that he did not know of anyone else who was discriminated against under HHC's alleged policy.

The district court dismissed Ukeje's state law claims. Because the federal claim was being dismissed and there was no allegation that the parties were diverse, the district court declined to exercise supplemental jurisdiction over the state law claims.

Ukeje v. N.Y. City Health & Hosps. Corp., No. 10-8389 (S.D.N.Y. Nov. 4, 2011)

Review board's decision to revoke physician's license affirmed

The New York Supreme Court, Appellate Division, Third Department, held that a physician whose medical license was revoked was not deprived of his right to a fair hearing and due process.

Dr. Nessim Roumi, a physician licensed to practice medicine in New York, was charged by the Bureau of Professional Medical Conduct (BPMC) with practicing medicine with negligence on more than one occasion, incompetence on more than one occasion, and failure to maintain accurate medical records in connection with his care and treatment of five patients. Following a hearing, the Hearing Committee of the State Board for Professional Medical Conduct sustained each of the charges and suspended Roumi's license for six months, placed him on probation for one year and fined him $30,000.

The BPMC appealed the hearing committee's decision to the Administrative Review Board for Professional Medical Conduct (ARB), which sustained the charges but modified the penalty by revoking Roumi's license. Roumi sued seeking to annul the ARB's determination.

The appellate division concluded that the ARB found that the harsher penalty of revocation was justified since Roumi's prescribing practices repeatedly placed patients at risk and there was nothing to indicate that he realized his deficiencies or understood the need to correct them. The ARB further found that the "gaps in knowledge and bad practices that developed over a long career" could not be remedied by the imposition of a lesser sanction, i.e., a probationary period and continuing medical education.

The appellate division also noted that, despite the petitioner's assertion to the contrary, the fact that none of the patients at issue suffered any actual harm does not preclude revocation of his license. Considering all of the facts and circumstances of this case, the appellate division held that it could not conclude that the penalty of license revocation is "so incommensurate with the offense as to be shocking to one's sense of fairness" and affirmed the administrative review board's order.

Roumi v. State Bd. for Prof'l Med. Conduct, No. 7763 (N.Y. App. Div. Nov. 3, 2011)

U.S. Supreme Court

Internet pharmacy owner's conviction for money laundering affirmed

The Supreme Court declined to review a decision of the Second U.S. Circuit Court of Appeals affirming the conviction of the owner of an Internet pharmacy for money laundering and drug offenses.

The owner of an Internet pharmacy that filled prescriptions without requiring any interaction between the doctors who approved the prescriptions and the purchasers of the prescriptions was convicted of distribution of controlled substances and money laundering.

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The Second Circuit affirmed the convictions. The Second Circuit held that any error in instructing the jury on a conscious avoidance theory was not prejudicial to the defendant because there was overwhelming evidence presented at trial that the defendant knew or reasonably should have known that the doctors and pharmacists upon whom he relied were acting in bad faith. The Second Circuit also held that *United States v. Santos*, 553 U.S. 507 (2008)—in which the Supreme Court concluded that the term "proceeds" in the federal money laundering statute means profits, not gross receipts—as applied to the sale of contraband, permits a conviction for money laundering conspiracy even absent proof that the laundered funds were profits.

Quinones v. United States, 635 F.3d 590 (2d Cir. 2011), *cert. denied*, No. 11-563 (U.S. Dec. 5, 2011)

FCA action against medical device manufacturer alleging kickbacks may proceed

The Supreme Court will not review a First U.S. Circuit Court of Appeals' decision reversing the dismissal of a qui tam action brought against a medical device manufacturer pursuant to the False Claims Act.

The relator claimed that the manufacturer knowingly caused hospitals and physicians to submit materially false or fraudulent claims to Medicare and engaged in a nationwide kickback scheme to induce physicians to use its medical devices in spinal surgeries when it knew the scheme would cause physicians and hospitals to unwittingly present federal healthcare programs with payment claims that contained material misrepresentations.

The First Circuit reversed the district court's dismissal of the claims. The First Circuit held that the allegations of misrepresentation were sufficient to state a claim that the hospital and physician claims for payment at issue here were false or fraudulent and that the kickbacks alleged were capable of influencing Medicare's decision as to whether to pay the hospital and physician claims. (For an earlier decision in this case, see 19 **HLawWk** 215, Apr. 2, 2010.)

Blackstone Med. Inc. v. U.S. ex rel. Hutcheson, 647 F.3d 377 (1st Cir. 2011), *cert. denied*, No. 11-269 (U.S. Dec. 5, 2011)

"Pharmaceutical industry" is not relevant product market for antitrust claims

The Supreme Court declined to review a Ninth U.S. Circuit Court of Appeals decision affirming the dismissal of an antitrust complaint arising from the merger of two pharmaceutical companies.

Independent retail pharmacies brought suit against Pfizer Inc. and Wyeth alleging that the merger of the two companies violated § 7 of the Clayton Act and § 1 of the Sherman Act. The district court dismissed the complaint on the basis that it failed to sufficiently allege a relevant product market for the antitrust action.

The Ninth Circuit affirmed the district court's dismissal. The Ninth Circuit held that the plaintiff's complaint—which defined the relevant product market as "the pharmaceutical industry"—failed to state any facts indicating that all pharmaceutical products are interchangeable for the same purpose and, therefore, the plaintiff's complaint was "facially unsustainable."

Golden Gate Pharmacy Servs. Inc. v. Pfizer Inc., No. 10-15978 (9th Cir. 2011), *cert. denied*, No. 11- 471 (U.S. Dec. 12, 2011)

FCRA does not preempt claim alleging debt collector disclosed medical information

The U.S. Supreme Court will not review a decision of the California Supreme Court reversing the dismissal of a patient's claim that a debt collector disclosed confidential medical information to credit reporting agencies in violation of state law.

The plaintiff alleged that his dentist referred a debt seeking payment for a procedure the plaintiff claimed he never received to a debt collection agency, which in turn repeatedly disclosed the contents of the plaintiff's and his children's dental records to credit reporting agencies. The plaintiff sued the debt collection agency for violations of California's Confidentiality Act, which prohibits the unauthorized dissemination of individually identifiable medical information. The trial court dismissed the claims and an appeals court affirmed, holding that they were preempted by the Fair Credit Reporting Act (FCRA).

The California Supreme Court reversed the judgment of the court of appeal. The supreme court concluded that Congress did not intend for the FCRA to preempt state laws regulating medical privacy and relieve entities otherwise obligated to maintain confidentiality of the duty to do so when reporting credit information.

Mortensen v. Brown, No. S180862 (Cal. 2011), *cert. denied*, No. 11-434 (U.S. Dec. 12, 2011)

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In The Law Journals

Medical residents and employment disputes

Robert N. Wilkey, *The Non-Negotiable Employment Contract—Diagnosing the Employment Rights of Medical Residents*, 44 Creighton L. Rev. 705 (2011)

In order to complete their medical education, medical school graduates must place in a medical residency program, usually at a teaching hospital. Because of this requirement, medical residents make up a large percentage of the healthcare personnel in the country. However, the working conditions for these medical residents are not always optimal. According to Robert N. Wilkey, courts and legislators need to pay attention to the employment issues faced by medical residents.

As noted above, medical residents have already graduated from medical school and are therefore obtaining advanced training from fully licensed physicians. The medical residents treat real patients in a real hospitals and clinics. Medical residencies usually last at least one year but in most cases last several years. Medical residents provide a significant benefit to the healthcare industry and especially to the hospitals where they are completing their residencies, but the training aspects of medical residencies have allowed the teaching hospitals to avoid classifying the medical residents as "employees."

In order to be accepted to work at a teaching hospital, medical school graduates participate in the National Residency Match Program (NRMP). The NRMP has been around since 1952 and involves a matching system between the medical school graduate and the teaching hospital. However, the NRMP does not allow the medical resident to discuss offers among various teaching hospitals, so the bargaining power of the medical resident is diminished. In addition, medical school graduates can only be released from a contract with a teaching hospital that the medical school graduate has been matched to through the NRMP. If the NRMP does not grant the waiver, the student can face significant penalties.

The contract terms provided by the teaching hospital that the medical school graduate has been matched to through the NRMP are basically non-negotiable. Generally, the contracts include information about the duty hours that a medical resident will work, and the contracts usually include due process clauses and procedures for the medical residents to submit grievances. Also, the contracts usually include sexual harassment policies, termination provisions and non-discrimination clauses. Finally, most of the contracts describe an evaluation process and the procedure for obtaining a certificate of completion.

The contract provisions in the agreement through the NRMP may be supplemented by the standards set forth by the Accreditation Council for Graduate Medical Education (ACGME). The ACGME provides that medical residents must be given written notice of the terms and conditions of employment, and the ACGME sets forth the requirements for the evaluations that the medical residents will receive during the course of their medical residencies. Also, the ACGME sets forth guidance regarding duty hours and sexual harassment policies.

Medical residents have challenged the NRMP's procedures in court, but Congress has expressed approval of the matching process by exempting the matching process from antitrust laws. In addition, discrimination lawsuits brought by medical residents against teaching hospitals have been unsuccessful. Similarly, courts have generally not been favorable to medical residents in cases in which the medical residents challenged the due process and administrative remedies of the teaching hospitals.

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