Exam ID # _____

WIDENER UNIVERSITY SCHOOL OF LAW

HEALTH LAW I MIDTERM EXAM

Professor Pope **Fall 2008**

GENERAL INSTRUCTIONS:

1. **Honor Code:** While you are taking this exam, you may not discuss it with anyone.

2. **Competence:** Accepting this examination is a certification that you are capable of completing the examination. Once you have accepted the examination, you will be held responsible for completing the examination.

3. **Exam Packet:** This exam consists of fourteen (14) pages, including this cover page. Please make sure that your exam is complete.

4. **Identification:** Write your exam number in the space provided in the upper-right hand corner of this page. Write your exam number on the cover of each Bluebook (or your ExamSoft file) that you use for Parts Two and Three.

5. **Anonymity:** The exams are graded anonymously. Do not put your name or anything else that may identify you (except for your student number) on the exam.

6. **Timing:** This exam must be completed within eighty (80) minutes. Time will commence ***after*** everyone has completed reviewing the instructions.

7. **Scoring:** There are 80 points on the exam, one per minute. Thus, you should allot a twenty (20) point question approximately twenty (20) minutes.

8. **Open Book:** This is an OPEN book exam. You may use ***any*** written materials, including, but not limited to: the Hall casebook, other required and recommended materials, any handouts from class, PowerPoint slides, class notes, and your own personal or group outlines. You may not use a computer other than in its ExamSoft mode.

9. **Format:** The exam consists of three (3) parts which count toward your grade in proportion to the amount of time allocated.

PART ONE comprises twelve (12) multiple choice questions worth a ***combined*** total of 24 points. The suggested completion time is 24 minutes.

PART TWO comprises one short essay questions worth sixteen points. The suggested completion time is 16 minutes.

PART THREE comprises one long essay question worth forty points. The suggested completion time is 40 minutes.

10. **Grading:** All exams will receive a raw score from zero to 80. The raw score is meaningful only relative to the raw score of the other students in the class. The raw score will be converted to a scaled score, based on the class curve. For example, if the highest raw score in the class were 60 of 80, then that student would typically receive an "A." I will post an explanatory memo and/or a model answer to TWEN a few weeks after the exam. L.L.M. and M.J. students are curved separately.

11. **Special Instructions:** Instructions specific to each exam section are printed immediately below.

SPECIAL INSTRUCTIONS FOR PART ONE:

1. **Format:** This Part contains twelve (12) multiple choice questions, worth a combined total of 40 points. This part has a suggested completion time of 40 minutes. Please note that the questions vary in both length and complexity. You might answer some in 30 seconds and others in three minutes.

2. **Identification:** Write your Student ID on the first page of this exam booklet.

3. **Circle the Best Answer:** Clearly mark your answer on this exam booklet itself. Circle the letter (*e.g.* A, B, C) containing the best answer.

4. **Ambiguity:** If (and only if) you believe the question is ambiguous, such that there is not one obviously best answer, neatly explain why in the margin near the question. Your objection must (i) identify the ambiguity or problem in the question and (ii) reveal what your answer would be for all possible resolutions of the ambiguity. I do ***not*** expect this to be necessary.

SPECIAL INSTRUCTIONS FOR PARTS TWO AND THREE:

1. **Submission:** Write your answers in your Bluebook examination booklets or ExamSoft file. I will not read any material which appears only on scrap paper.

2. **Legibility:** Write legibly. Please write only on one side of the page. I will do my best to read your handwriting, but must disregard (and not give you points for) writing that is too small to read or otherwise illegible.

3. **Outlining Your Answer:** You are strongly encouraged to use one-fourth of the allotted time per question to outline your answers on scrap paper ***before*** beginning to write in your exam booklet or ExamSoft file.

   Do this because you will be graded not only on the substance of your answer but also on its clarity and conciseness. In other words, organization, precision, and brevity count. If you run out of insightful things to say about the issues raised by the exam question, stop writing until you think of something. Tedious repetition, regurgitations of law unrelated to the facts, or rambling about irrelevant issues ***will*** negatively affect your grade.

4. **Answer Format:** This is important. ***Use headings and subheadings***. Use short single-idea paragraphs (leaving a space between paragraphs). Much less important, but sometimes helpful, are introductory roadmaps.

5. **Answer Content:** Answer all (but only) relevant issues that arise from the fact pattern. Do not just summarize all the facts or all the legal principles relevant to an issue. Instead, ***apply*** the law you see relevant to the facts you see relevant. Take the issues that you identify and organize them into a coherent structure. Then, within that structure, examine issues and argue for a conclusion.

6. **Citing Cases:** You are welcome but not required to cite cases. While it is sometimes helpful to the reader and a way to economize on words, do not cite case names as a substitute for stating the law. For example, do ***not*** write: "Plaintiff should be able to recover under *Canterbury*." Why? What is the rule in that case? What are the facts in the instant case that satisfy that rule?

7. **Cross-Referencing:** You may reference your own previous analysis. But be very clear and precise what you are referencing. As in contract interpretation, ambiguity is construed against the drafter.

8. **Balanced Argument:** Facts rarely perfectly fit rules of law. So, recognize key weaknesses in your position and make the argument on the other side.

9. **Additional Facts:** If you think that an exam question fairly raises an issue but cannot be answered without additional facts, state clearly those facts (implied by or at least consistent with the fact pattern) that you believe to be necessary to answer the question.

STOP !

STOP !

DO NOT TURN THIS PAGE UNTIL THE PROCTOR SIGNALS

PART ONE

12 questions worth 2 points each = 24 points/minutes

1. Plaintiff alleged the following in a recently-filed complaint. What cause of action do these allegations BEST support?

22. In December 2003, Pam Smith first visited the Doctors Office in Nashville, Tennessee. Ms. Smith met with employees of the Doctors Office who evaluated her, and noted in her medical chart the appropriate laser surgery to correct Ms. Smith's vision.
23. On January 9, 2004, Ms. Smith returned to the Doctors Office for her scheduled eye surgery to be performed by Dr. Sanders. The Doctors Office gave Ms. Smith a nametag to identify her to Dr. Sanders and the Doctors Office staff throughout her eye surgery.
24. Because Ms. Smith would be lying on her back during the surgery, the Doctors Office staff turned Ms. Smith's nametag upside-down so that Dr. Sanders could read it.
25. Nonetheless, Dr. Sanders performed laser surgery that was intended for another patient on both of Ms. Smith's eyes.
26. Soon after Dr. Sanders discharged Ms. Smith, someone from the Doctors Office called Ms. Smith and directed her to return immediately because the doctor needed to see her.
27. When Ms. Smith arrived, Dr. Sanders informed her that he had made a mistake and performed the wrong surgery on Ms. Smith.
28. At the same meeting, a person from the Doctors Office informed Ms. Smith that Ms. Smith's chart had been confused with another patient's chart.
29. Ms. Smith's vision is now worse than it was before Dr. Sanders performed surgery on her eyes. Ms. Smith also continues to experience pain and discomfort as a result of the surgery.

A. Informed consent

B. Battery

C. EMTALA

D. Breach of confidentiality

E. ADA

2. **Smithson arrived at the emergency room of Regional Medical Center with an eye injury. Smithson complained that a foreign object had entered his left eye while using a weedeater 10 to 15 minutes earlier. Smithson was immediately seen by the Emergency Room physician, Dr. Hansen. Hansen diagnosed the plaintiff with an "open globe injury." Within five minutes of seeing the patient, Hansen consulted via telephone with Dr. Hemelt, the on-call ophthalmology consultant. Hemelt told Hansen to order a CAT scan to see if there was a foreign body in the patient's globe. After the CAT scan, at around 9:45 a.m., Hanson called Hemelt with the results, and Hemelt told him to prepare the preoperative lab work. Hemelt told Hanson that he would be in for surgery around noon, after his clinic. When Hemelt arrived, he told plaintiff that he needed surgery for urgent repair. But, allegedly after his insurance status was reviewed, at about 2:30 p.m., plaintiff was transferred to the Medical Center of Louisiana at New Orleans (Charity Hospital).**

Smithson left via ambulance for Charity Hospital and arrived at 4:55 p.m. Smithson waited in the emergency room at Charity, was not examined until 7:30 p.m., and went into surgery at 10:30 p.m., about 15 hours after arriving at the Regional Medical Center emergency room. The next morning, the Charity doctors detected an infection in Smithson's eye, and three days later, his eye was removed. Smithson 's expert Dr. Bucci reported that any delay in treatment of an open globe would "result in loss of tissue" and "progressively increase the risk of infection."

Plaintiff's claim against Regional Medical Center under EMTALA:

A. Will likely succeed because of the hospital's failure to do the required screening

B. Will likely succeed because of the hospital's failure to stabilize Smithson prior to transfer

C. Both A and B

D. Neither A nor B

3. On March 17th, Stowe arrived at the emergency room at the Medical Center. Dr. Hartman noted that Stowe was experiencing pain in his back and that Stowe could neither move his right leg nor walk. A CT scan of Stowe's lumbar spine revealed severe stenosis of L4-5 and narrowing at L5-S1. Stowe was discharged from the Medical Center, with orders to see an orthopedic surgeon the following morning.

By the time Stowe visited with Dr. Slabisak, the orthopedic surgeon, as instructed, Stowe experienced a marked worsening of his paralysis. On March 27th, Slabisak performed a decompressive laminectomy. On March 28th, Stowe underwent a second surgical procedure. However, Stowe's spinal cord function did not return. On April 12th, Stowe was transferred to HealthSouth for in-patient rehabilitation. Stowe is now a permanent T12 paraplegic, suffering bladder and bowel incontinence.

Stowe contends that the Medical Center was aware that he was uninsured and aware of his inability to pay when it failed to perform x-rays or an MRI of his thoracic spine, when he first presented to the emergency room.

Stowe's claim under EMTALA will likely:

A. Fail - because the Medical Center had no duty to stabilize if it did not know of his emergency medical condition

B. Fail – if a reasonably prudent health care provider would have provided the same screening that the Medical Center did

C. Succeed - if the Medical Center failed to offer Stowe the same screening that it would have offered any other patient in a similar condition

D. Succeed - if the Medical Center failed to offer Stowe the same screening to which a reasonably prudent patient in his position would have consented

Use the following fact pattern for BOTH Questions 4 and 5.

Lopez arrived at Ryder's Emergency Room complaining of bleeding from a femoral dialysis catheter and chest pain. Dr. Pastrama entered a comprehensive set of orders. Later, Dr. Kidd ordered the admission of Lopez to the hospital under his supervision because of bleeding from his graft. It was documented that he was pale, alert, feverish with edema, weak, and suffering from slight respiratory distress and chest pain.

Lopez continued to have "lots of bleeding" in the area of the incision. That night, Kidd telephoned the following order: apply pressure to the area that is bleeding and change the bandage; type and cross for four units of frozen plasma to transfuse in the morning with dialysis. Lopez's bandages were changed on several occasions. Kidd requested a consultation with Dr. Canetti. At 7:00 a.m., Dr. Canetti examined

Lopez and noted that he was acutely ill but not bleeding at that moment. He also ordered the transfer of Lopez as soon as possible to another facility to repair Lopez's broken fistula. At that time Lopez was reported to be in a delicate condition, and a transfusion of fresh frozen plasma platelets had begun. Lopez was pronounced dead at 8:15 a.m.

4. In an EMTALA lawsuit by the patient's family:

A. Defendant Kidd's motion for summary judgment should be granted.

B. Defendant Kidd's motion for summary judgment should be denied.

C. There is not sufficient information to evaluate the EMTALA claim against defendant Kidd.

5. In an EMTALA lawsuit by the patient's family:

A. Defendant Canetti's motion for summary judgment should be granted.

B. Defendant Canetti's motion for summary judgment should be denied.

C. There is not sufficient information to evaluate the EMTALA claim against defendant Canetti.

6. Which of the following statements is the MOST accurate?

A. The purpose of EMTALA was to guarantee that all patients are properly diagnosed.

B. The purpose of EMTALA was to ensure that all patients receive adequate care.

C. The purpose of EMTALA was to provide an adequate first response to a medical crisis for all patients.

D. EMTALA creates a federal cause of action for medical malpractice.

7. Melba Haight developed a urinary tract infection and began using the antibiotic Levaquin, as prescribed by her physician, Dr. Robertson. A few days later, Ms. Haight wasn't responding well to the medication and had a decreased appetite and increased heart rate. Ms. Haight's family summoned emergency aid from Southwestern Medical Ambulance Service, who transported Ms. Haight to the St. Joseph Regional Medical Center. As a result of Ms. Haight's worsening condition, Dr. Robertson ordered her to be admitted to the St. Joseph Regional Medical Center's Progressive Cardiac Unit, and thereafter to the Intensive Care Unit. Ms. Haight remained a patient in the ICU until her death.

Plaintiff alleges that the St. Joseph Regional Medical Center failed to properly provide medical screening under EMTALA. To prove this violation, plaintiff has proffered expert medical testimony as to what treatment the standard of care requires that a patient in Ms. Haight's position be provided. Plaintiff's experts testified that St. Joseph's screening, while not arbitrary or irrational, was still negligent because it fell below the standard of care.

Plaintiff's evidence is:

A. Sufficient to establish an EMTALA violation – defendant's motion for summary judgment should be denied

B. Not sufficient to establish an EMTALA violation – defendant's motion for summary judgment should be granted

C. There is not sufficient information to tell whether or not this evidence is sufficient to establish an EMTALA violation

8. Dr. Wynn operated on the plaintiff's right rotator cuff at Shenandoah Memorial Hospital. The rotator cuff surgery was performed under interscalene block anesthesia. During the administration of the anesthesia, the plaintiff sustained an injury to his phrenic nerve, which resulted in the paralysis of his right diaphragm.

Plaintiff alleged that the defendants acted negligently, in that they failed to inform him of the risks associated with the interscalene block. But plaintiff has no evidence to support his allegation that the defendants failed to inform him of the risks associated with the performance of the interscalene block. There are no witnesses, aside from the plaintiff, who can provide testimony regarding the defendants' alleged failure to inform the plaintiff of the risks. And during his deposition, the plaintiff testified that he has no memory of either the defendants or the anesthetic procedure.

Plaintiff's major DIFFICULTY in making a claim for informed consent will be in establishing:

A. Duty

B. Breach

C. Causation

D. Damages

9. Hutt signed the following hospital consent form:

I, the undersigned, agree to be admitted to Hospital for purposes of removing my gall bladder, using a telescopic camera and instruments to avoid a large abdominal wound. I further authorize Hospital personnel to perform such laboratory examinations of blood, serum, or other body fluids as may be necessary to confirm the presence or absence of communicable diseases including, but not limited to, hepatitis B, human immunodeficiency virus (AIDS), and syphilis.

Because of this consent form, if his gall bladder surgery goes badly, Hutt probably cannot make a plausible claim for:

A. Battery

B. Informed consent

C. Both A and B

D. Neither A nor B

10. Failure to arrange for language interpreters for patients with limited English language proficiency is considered national origin discrimination in violation of:

A. ADA

B. Hill Burton

C. Title VI of the Civil Rights Act of 1964

D. Rehabilitation Act of 1973

11. Wiggler is an inpatient at Creek Hospital, receiving treatment from Dr. Charles for a spinal fracture. Wiggler now wants to leave the hospital, risking paralysis and even death that could be prevented by continued care in the hospital. Wiggler knows that he is acting against medical advice but is unaware of the hazards of leaving AMA.

If Wiggler is later paralyzed, he can state a decent claim:

A. Against the hospital under EMTALA

B. Against Dr. Charles under EMTALA

C. Against Dr. Charles for informed consent

D. Against the hospital for informed consent

E. Two or more of the above

12. Linda arrived at the Crozer-Chester ER with a leg laceration. The ER physician performed the standard screening for that condition. Then, upon realizing that Linda was uninsured, discharged her without treating the laceration.

Crozer-Chester has:

A. Violated EMTALA since it refused to treat Linda based on her inability to pay

B. Violated EMTALA only if a failure to treat the laceration would likely result in material deterioration of that condition

C. Not violated EMTALA since it performed the standard screening for a patient presenting with Linda's condition

D. Not violated EMTALA since it did not transfer Linda to another hospital or facility

E. None of the above

---------- END OF PART ONE ----------

PART TWO

1 short essay question worth 16 points = 16 points/minutes

SHORT ESSAY ONE: (16 points/minutes)

In 2005, 49-year-old Roseanne had a high-risk pregnancy involving *in vitro* fertilization. She was a patient under the care of doctors at the Uh-Oh OB Clinic. But Roseanne suffered a miscarriage that she alleged had resulted from negligent treatment by Dr. Nugent. Roseanne sued Dr. Nugent for medical malpractice.

In 2007, Roseanne became pregnant again and began treatment with Dr. Cosmo, also at the Uh-Oh OB Clinic. Plaintiff was scheduled for a cerclage (a surgical procedure in which the cervix is sutured during pregnancy to prevent it from opening prematurely). After she was admitted for surgery, Dr. Cosmo informed Roseanne that he would not be performing the procedure because she had filed a lawsuit against his partner Dr. Nugent. Roseanne obtained a referral to another obstetrician, who performed the cerclage nine days later. Plaintiff subsequently suffered another miscarriage.

Describe and evaluate Roseanne's best legal claim(s) against Dr. Cosmo.

---------- END OF PART TWO ----------

PART THREE

1 long question worth 40 points = 40 points/minutes

LONG ESSAY: (40 points/minutes)

In 2004, Dentist Ferrara implanted a prosthesis in patient Pisano's left jaw during surgery to repair facial injuries. While the actual surgery was uneventful, the patient has brought a lawsuit concerning the dentist's post-operative treatment. Post-operative treatment is a standard part of surgery.

The prosthesis was coated with proplast, a substance made of Teflon-carbon or Teflon-aluminum oxide fiber composite, which was later found to cause tumors. In 2005, the Food and Drug Administration (FDA) issued advisories to the oral and maxillofacial surgery community warning that the implanted proplast was becoming a source of foreign body reaction. As one expert explained, the Teflon in the implant was breaking down, and the body was "forming Giant Cell reactions to literally get rid of the proplast, but at the same time it was also causing damage to bone and the associated tissues around it." The damage could cause intense pain and limit joint function.

Consequently, the FDA recalled all such unused implants and recommended that symptomatic and asymptomatic "patients with these implants who have not had a radiograph taken in the past six months undergo immediate and appropriate radiographic examination," which would determine if the implant had lost integrity and if progressive bone degeneration had occurred. To this end, surgeons were urged to contact and re-examine patients with proplast implants and perform either a CT scan or MRI to detect the presence of giant cell reaction.

A second public health advisory was issued by the FDA in 2006. The advisory warned all health care professionals that the implants distributed between 1973 and 2005 presented a "hazard to the health of patients" and reiterated the warnings in the 2005 safety alert. As to those patients with the implants who had not yet been notified of the potential for bone deterioration, the advisory recommended they be contacted as soon as possible. An MRI or CT scan should then be performed to detect any bone degeneration, and asymptomatic patients should thereafter be reviewed annually.

Despite these warnings, Dentist did not contact Pisano, and, in fact, did not see Pisano after the 2004 surgery until January 2008, when Pisano, after suffering a minor trauma to his jaw, presented with equilibrium problems and headaches that pre-dated the trauma. According to Pisano, Dentist never mentioned the FDA warning at the time. Moreover, during the visit, Dentist never performed diagnostic testing nor suggested implant extraction or annual monitoring.

Thereafter, Dentist neither saw Pisano nor communicated with Pisano again until July 2008, when Pisano presented with the same symptoms as before-equilibrium, balance and headaches-but this time more exaggerated and frequent. Pisano also complained of ringing in his ears (tinnitus) and a "pins and needles" sensation in his jaw area. Despite these being recognized symptoms of potential giant cell reaction, Dentist never mentioned either of the FDA warnings nor did he perform diagnostic testing or suggest extraction or annual monitoring.

Eventually, sometime in September 2008, Dentist informed Pisano that his implant had to be removed. For insurance reasons, Pisano was referred to Dr. Quinn, who performed the surgery. During the operation, Dr. Quinn removed the prosthesis as well as the giant cell reaction and all abnormal and inflamed surrounding tissue, grafted bone from Pisano's lower jaw to create a new socket, and placed a new prosthesis in it. In addition to the giant cell reaction, extensive damage to Pisano's bone structure was revealed when Dr. Quinn removed the implant including major bone loss on any surface touching proplast, loss of most of the fascia bone, erosion to the middle of the cranial fascia, and skeletonization of the mandible resulting in nerve exposure.

In early October 2008, a jury (in a material risk, *Canterbury* jurisdiction like DC, NJ, CA) rendered a verdict and $65,000 damages on Pisano's claim for informed consent. The Dentist has appealed the judgment on the verdict. You are Pisano's appellate lawyer. Explain why the trial court judgment for plaintiff should be affirmed.

---------- END OF PART THREE ----------