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PREFACE

The purpose of the 2010 MHA Health Care Consent Manual is to provide Montana health care facilities with one resource addressing the various state and federal requirements pertaining to health care consents and health care information. The Consent Manual’s CD format will make it possible to incorporate changes in the law and add new material more frequently. MHA welcomes your comments and suggestions for future updates.

The 2010 MHA Health Care Consent Manual is revised and expanded from previous editions to include revisions to applicable state and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d et seq., and the regulations that implement HIPAA’s privacy protections. 45 C.F.R. parts 160 and 164 (“HIPAA Privacy Rule.”) Other specific areas of the law which have underwent substantial changes over the past five years and/or which are now contained in this Consent Manual are newborn screening regulations, adoption and surrogacy laws, HIV/AIDS testing protocols and issues relating to deceased individuals and anatomical gifts.

While efforts will be made to keep these resources up to date, please be aware that laws, including court interpretations of existing laws, change constantly and legal counsel should be consulted in appropriate circumstances. Furthermore, the forms in this Consent Manual are for general information only and are not a substitute for legal advice when drafting forms for a particular purpose. Finally, the Consent Manual is intended for HIPAA-compliant health care facilities. Providers and facilities that are not subject to HIPAA may find some of the material helpful, but these providers are subject to the Montana Uniform Health Care Information Act, not the HIPAA Privacy Rule, and their legal obligations concerning health care information are somewhat different. See the Montana Uniform Health Care Information Act, Montana Code Annotated, Title 50, chapter 16, part 5.
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CHAPTER 1 - THE NATURE OF CONSENT - WHO AND WHY

1.1 Use of Manual
The MHA Health Care Consent Manual is intended as a guide only and is not a substitute for competent legal advice. The forms in the Consent Manual are intended as a resource to be used and adapted, with appropriate legal advice, to the needs of each individual facility.

1.2 Consent to Treatment vs. Consent to Use and Disclose Information
Like its predecessors, this edition of the MHA Health Care Consent Manual covers two distinct areas involving health care “consent.” The first area is consent to treatment: health care providers must generally obtain informed consent prior to providing treatment. What constitutes valid consent to treatment is usually a matter of state law. The second area is consent to use and disclose health care information. Use and disclosure of individual health care information is governed by the HIPAA Privacy Rule, 45 C.F.R. parts 160 and 164, as well as Montana state law. An overview of consent to treatment follows in this Chapter 1. Chapter 2 contains an overview of consent to use or disclose health care information, especially with respect to health care providers subject to the HIPAA Privacy Rule.

1.3 Requirement of Consent
A competent individual has the right to refuse medical treatment, even if the consequences of such refusal are life-threatening. The Montana Constitution’s Right to Privacy, found at Article II, Section 10, incorporates a “personal autonomy component” that includes “the right of each individual to make medical judgments affecting her or his bodily integrity and health in partnership with a chosen health care provider free from the interference of the government ….” Armstrong v. State, 1999 MT 261, ¶ 39, 296 Mont. 361, ¶ 39, 989 P.2d 364, ¶ 39.

In addition, a legal theory traditionally used to support the individual's right to refuse medical treatment is the tort of battery. Battery is defined as the unlawful application of force to the person of another. Although the intent behind non-consensual medical treatment is very different from what is often thought of as battery - a physical attack on another person - it nonetheless is a technical battery.

A technical battery occurs when a physician or dentist, in the course of treatment, exceeds the consent given by a patient. Although no wrongful intent is present, and in fact there may be a sincere purpose to aid the patient, recovery is permitted unless there is an emergency.

Black’s Law Dictionary 139 (5th ed., West 1979). In addition to constituting a battery, the failure of a medical professional to obtain patient consent to a medical procedure is malpractice. Bakewell v. Kahle (1951), 125 Mont. 89, 232 P.2d 127.

1.4 Informed Consent
In recent times, the requirement of consent to medical treatment has been refined to require that such consent be informed; that is, the patient must have sufficient information upon which to base his or her consent. The information that must be provided will vary depending upon the patient, the particular treatment or procedure involved, and the type of health care professional involved (i.e., surgeon, anesthesiologist, dentist).

1.5 Matters to Consider in Obtaining Informed Consent
The following matters should be considered when obtaining informed consent:

A. Diagnosis
The patient must know his or her condition. Any uncertainty concerning the correctness of the diagnosis must also be disclosed.

B. Purpose
The purpose of the proposed treatment or procedure and what it entails must be explained to the patient in terms that can easily be understood by a layperson. If the treatment or procedure will be performed by a student, colleague, or any person other than the physician obtaining informed consent from the patient, this must be disclosed.

C. Risks and consequences of proposed treatment
Risks and consequences of the proposed treatment must be disclosed, including serious risks which have a small probability of happening as well as frequent but less serious risks.

D. Likelihood of success
The patient must receive a realistic assessment of the likelihood that the treatment or procedure will be effective.

E. Alternatives to treatment or procedure
Feasible alternatives to the proposed treatment or procedure must be disclosed, along with their risks.

F. Consequences of refusal of treatment
The patient must know the prognosis if the treatment is not given or the likely consequences if the procedure is not performed.

1.6 The Legal Standard for Determining Whether Informed Consent was Obtained
In Montana, the legal duty of a physician to disclose information in order to assure that informed consent is obtained from a patient is limited to those disclosures which a reasonable practitioner would make under similar circumstances. Doerr v. Movius (1970), 154 Mont. 346, 463 P.2d 477.

1.7 Duties of Health Care Facility Concerning Informed Consent
Generally, the patient's physician has the primary duty to obtain the patient's informed consent concerning treatment performed by the physician. However, informed consent relates to the health care facility in several ways.

A. Employees
Liability for the failure of an employee health care professional to obtain informed consent is attributable to the health care facility under the legal theory of respondeat superior. That is, the employer is liable for the acts of the employee when the employee is acting in the course and scope of employment. The theory of respondeat superior would likely apply in the event of the failure of any hospital-employed health care provider to obtain informed consent, including employed emergency room physicians, radiologists, pathologists and anesthesiologists. Presumably, the increasing incidence of health care facilities employing physicians may be expected to result in more health care facility liability claims based on respondeat superior.

B. Other Health Care Practitioners
When responsibility for obtaining informed consent rests with a physician or other practitioner who is not an employee of the health care facility, the facility is not automatically liable for the practitioner's failure to obtain informed consent. However, the health care facility is responsible for taking all reasonable measures to ensure that patient care meets applicable professional and legal standards.


1.8 The Role of a Written Consent Form
No legal requirement exists that a patient sign a written consent form, except in a few specific situations. Mandatory written consent forms include consent to abortion and consent to inpatient treatment for mental illness. An appropriate consent form or forms, however, have value as evidence that informed consent has been obtained. A generalized “blanket” consent form is of little or no value in determining whether informed consent has been obtained; in fact, a danger exists that the use of such a form will result in laxity in obtaining actual informed consent. A consent form should never be used as a substitute for the one-on-one process of obtaining informed consent. Nonetheless, an appropriate consent form may assist health care professionals in obtaining proper consent and will serve as a record (along with documentation in the patient's medical record) that informed consent has been obtained.

1.9 Length of Time Written Consents are Valid
A written consent is generally valid for a reasonable time after signing and no specific limitation in hours or days exists after which a new consent must be obtained. In accordance with the expectations of the patient and the health care facility, a general consent to treatment form signed at the time of admission will cover treatment received for the entire period of each hospitalization. Consent for a specific treatment or procedure (for example, consent to anesthesia or a particular surgery) is valid for the length of time needed to perform the particular treatment or procedure. As a general matter of health care facility policy, no consent should be deemed to be valid after the patient has been discharged from the confinement for which the consent was given.
1.10 Who Must Obtain Informed Consent

While anyone may be delegated to obtain consent, the health care provider who will perform a particular treatment or procedure is ultimately responsible for obtaining and documenting informed consent. For example, the physician who will perform surgery is responsible for obtaining consent to the surgery, and the anesthesiologist is responsible for obtaining consent to anesthesia. The physician who performs a procedure is liable for failure to obtain informed consent, not the referring physician. Llera v. Wisner (1976), 171 Mont. 254, 557 P.2d 805. Documentation that consent was obtained by the patient's regular physician in the patient's medical record does not excuse a substitute physician performing the procedure if, in fact, such consent was not obtained. Sangiolo v. Leventhal, 505 N.Y.S.2d 507 (N.Y.Sup. 1986). Of course, each health care facility employee who will provide routine services is not required to obtain and document consent to treatment for routine care. Upon admission, admitting personnel must obtain informed consent to routine services, diagnostic procedures and treatment, evidenced by a general consent to treatment form.

1.11 Consent by Fax, Email or Telephone

Consent by fax, email, telephone, or other electronic media is generally permissible. Consent by telephone should be used only in situations where time is of the essence and should be followed up with written consent.
CHAPTER 2. - THE HIPAA PRIVACY RULE AND CONSENT

2.1 In General
The federal HIPAA Privacy Rule, 45 C.F.R. parts 160 and 164, provides a framework regulating the use and disclosure of protected health information (“PHI”). The HIPAA Privacy Rule does not address consent to treatment issues, as opposed to “consent” in connection with the use or disclosure of PHI. In fact, the HIPAA Privacy Rule generally does not use the term “consent” when an individual’s permission to use PHI is required; such permission is called an “authorization.” (For more information on HIPAA-compliant authorizations, see Chapter 24.) In other situations, the individual must be given the opportunity to object to the disclosure of PHI. 45 C.F.R. § 164.510. Under such circumstances, failure to object may be presumed to constitute consent.

Not all health care providers are subject to the HIPAA Privacy Rule. Health care providers that are not subject to the HIPAA Privacy Rule must comply with the Montana Uniform Health Care Information Act, Montana Code Annotated, Title 50, chapter 16, part 5. The requirements of the Montana Uniform Health Care Information Act are beyond the scope of this MHA Consent Manual.

2.2 When a Provider is Subject to HIPAA - The Small Provider Exception
Montana has a dual statutory scheme for protecting an individual’s health care information. Federal law requires most health care providers to comply with the HIPAA Privacy Rule. However, some small providers that choose not to engage in electronic transactions are not subject to the HIPAA Privacy Rule. Electronic transactions include:

- Submitting claims information;
- Claims status transmissions;
- Eligibility transmissions;
- Referral certifications and authorizations;
- Enrolling in a health plan;
- Receiving health care payments and remittance advice; and
- Coordination of benefits.

To qualify for the small provider exception, all the transactions listed above must be conducted on paper, by telephone, or by fax machine (faxing from a computer counts as an electronic transaction.) A provider that would otherwise qualify for small provider status is not a small provider if it contracts its claims and billing functions to a third party.

Before the April 2003 effective date for the HIPAA Privacy Rule, the Montana legislature recognized that, unless it acted, facilities would be required to try to follow the similar but conflicting requirements of the HIPAA Privacy Rule and the Montana Uniform Health Care Information Act. Moreover, certain provisions of the Montana Uniform Health Care Information Act do not have parallels in the HIPAA Privacy Rule. The legislature also wanted to retain a few Montana statutory provisions that were more stringent than the HIPAA Privacy Rule. Accordingly, the legislature amended the Montana Uniform Health Care Information Act to apply only to non-HIPAA providers. Mont. Code Ann. § 50-16-502. The provisions the
legislature wanted to retain for providers subject to the HIPAA Privacy Rule are now found in Montana Code Annotated, Title 50, chapter 16, part 8.

### 2.3 Medicare Technical Requirements

The HIPAA Privacy Rule does not explicitly contain the small provider exception. As explained above, a small provider may choose not to engage in electronic transmissions and avoid compliance with the HIPAA Privacy Rule. While that may be the case, Medicare requires most providers to bill electronically. Because they must bill electronically, these providers are forced to conduct electronic transmissions and fall within the scope of the HIPAA Privacy Rule.

A health care provider that meets the definition of a small provider in Medicare’s small provider exception may continue to submit paper claims. 42 C.F.R. § 424.32. “Small provider” is

1. A provider billing a Medicare fiscal intermediary (e.g., a hospital, long term care facility or similar institution) that has fewer than 25 full-time equivalent employees (FTEs); or

2. A physician, practitioner, facility or supplier billing a Medicare carrier that has fewer than 10 FTEs.

42 C.F.R. § 424.32(d)(1). As stated above, in order to qualify for the exception, a small provider must do its own billing and not contract with a third party to handle claims.
CHAPTER 3 - CONSENT TO ADMISSION - Inpatient Treatment

3.1 In General
Upon admission, a health care facility requires the patient’s consent for several purposes. These include consent to routine hospital treatment, consent to payment arrangements, and notifying the patient of his or her options concerning use of protected health information (PHI) in accordance with the facility’s HIPAA Notice of Privacy Practices. (HIPAA Privacy Rule provisions governing the Notice of Privacy Practices are found at 45 C.F.R. § 164.520.)

An admission consent form may serve two of these purposes. First, the admission consent form documents the patient’s consent for routine procedures. Second, the admission consent form may evidence the patient’s consent to payment arrangements with the facility, such as assignment of insurance benefits and acknowledgement that the signee is obligated to pay the facility’s charges. If desired by the health care facility, the admission consent form provisions relating to routine hospital care may be placed on a separate form from consent provisions relating to the financial agreement between the patient and the facility. The admissions consent form should never be relied on as consent to any substantial medical or surgical procedure beyond routine treatment. In most cases, the health care facility will wish to ensure that the patient has signed a special consent form for every substantial medical or surgical procedure.

3.2 Consent to Admission from Parents or Guardian of Minor or Incompetent Person
A consent to admission form must generally be executed on behalf of a minor by the minor's parent or guardian. A full discussion of consent issues affecting minors is contained in Chapter 8. The consent to admission form for a minor or incompetent person must contain the parent or guardian's promise to be liable for payment if that is the understanding of the parties. A general admission consent form may be designed to function as a consent for admission of a minor or incompetent person as well; alternatively, a special form can be designed for this purpose. If a person professing to be the guardian of a minor or incompetent person is to sign the admission consent form, the guardian should provide verification of his or her guardianship such as a copy of the court order. See MHA Form 3-1, Admission Consent Form.

3.3 Consent to Operation, Administration of Anesthetics and the Rendering of Other Substantial Medical Services
In general, informed consent must be obtained and documented for each invasive, non-routine medical procedure. The primary drawback to the general consent form signed upon admission is that it may be relied upon to document consent to treatment other than routine care. For surgical procedures, the Medicare Conditions of Participation require an informed consent form. 42 C.F.R. 482.51. Courts have found that an all-inclusive, general consent to treatment of the type obtained on admission does not constitute legally adequate informed consent. See, e.g., Burton v. Brooklyn Doctors Hospital, 88 A.D.2d 217 (N.Y. App. Div. 1982). A special consent form for each significant procedure must be obtained as evidence that the patient gave informed consent. Again, however, a consent form is not a substitute for the explanation of the procedures to the patient; it merely documents that such information was provided and the patient consented to the procedure.
3.4 Content of Forms

A form purporting to be a “special” consent form may be ineffective unless it sets forth the specific information required to be disclosed for informed consent. A form that states “the nature of the procedure and all the significant risks attendant therein have been disclosed to me” may be insufficient documentation for informed consent purposes. For examples of special consent forms for medical procedures, see MHA Form 3-1, Admission Consent Form; MHA Form 3-2, Consent to Operation and Other Medical Procedures; MHA Form 3-3, Consent to Procedure; and MHA Form 3-4, Consent to Anesthesia. The health care facility may also wish to develop forms tailored to specific procedures.

3.5 Scope of Consent

The physician obtaining consent to a medical procedure has no right to go beyond the authorized scope of the procedure unless an emergency arises which makes additional consent impractical. An emergency situation cannot be used to justify a procedure to which a patient has previously refused consent.

3.6 Emergencies

If an individual or the individual’s representative cannot give informed consent, the individual may receive emergency treatment. Such treatment must only address the emergency, and the health care facility should attempt to obtain consent from the individual or the individual’s representative after the emergency has been remedied.
CHAPTER 4 - CONSENT TO OUTPATIENT SERVICES

4.1 Optional Use of Special Form
The health care facility may use the same form for outpatients that it uses for inpatients, or special outpatient forms may be developed. Provided they contain all the necessary elements, special forms for outpatients are probably preferable because they eliminate any confusion that may be caused by provisions contemplating inpatient treatment. Furthermore, an outpatient may be unwilling to sign a consent form that authorizes health care facility admission.

4.2 Content of Outpatient Consent Form
The outpatient consent form must document that informed consent has been obtained to the same extent that inpatient forms document informed consent. For health care facility inpatients, the preferred method of documenting consent is to request at least two forms: the admission consent form and a form evidencing consent to operation or other substantial or invasive medical procedure. Although the health care facility may continue to use two forms if it wishes, one form should be sufficient for purposes of documenting outpatient informed consent. Similar to inpatients, the medical professional who will provide the treatment is responsible for obtaining informed consent. As with any informed consent discussion, the following should be explained to the patient:

- The nature and purpose of the proposed procedure(s).
- The risk of the proposed procedure(s), including the risk that such treatment may not accomplish the desired objective(s).
- The possible or likely consequences of the proposed procedure(s).
- All feasible alternative treatments (including the risks, consequences, and probable effectiveness of each).
- The prognosis if no treatment is received.

See MHA Form 4-1, Consent to Outpatient Treatment.
CHAPTER 5 - REFUSAL TO CONSENT TO TREATMENT

5.1 In General
A competent adult has the right to refuse medical treatment. The treatment refused may be minor or lifesaving, and an individual may refuse treatment for any reason. See Chapter 20 for the right of an individual to make an advance directive requiring that life sustaining treatment be withdrawn if such individual is terminally ill. A health care facility or physician that knows for certain that a patient will refuse the recommended treatment is not obligated to admit or attempt to treat the patient. However, refusal to admit or treat the patient should not be used to coerce an ambivalent patient into consenting to the proposed treatment. Of course, the patient's competency must be determined before the patient's refusal to undergo treatment is honored. While not determinative, a patient's refusal to undergo treatment to which most people would consent may add to evidence of incompetence.

5.2 Risks of Refusal
Refusal of medical treatment must be an informed refusal. The health care facility and the patient's physician must make absolutely certain the patient understands the recommended treatment being refused. Whenever a patient or the patient's legal representative refuses blood, certain drugs, operations, or other substantial treatment recommended by the physician, the physician must explain to the patient or the patient's representative the reason for the proposed treatment and the possible adverse effects if the treatment is refused. If the patient continues to refuse the treatment, a full statement should be made on the patient's medical record. Administration should be informed of the refusal. The patient should be requested to sign a refusal of treatment form. See MHA Form 5-1, Refusal to Consent to Treatment. It is not a legal requirement to ask a patient to sign a refusal of treatment form; however, it constitutes evidence that the patient did refuse the treatment. If possible, the health care facility and physician should provide the patient with the best treatment available within the limitations of the refusal.

5.3 Refusal of Treatment For a Minor
Parents generally have the right to refuse medical treatment on behalf of their minor children. However, if the treatment proposed is likely to save the child's life or health, courts may be willing to intervene to require the treatment. The health care facility should establish a procedure in advance for applying for court order of such treatment. Of course, legal counsel should be consulted as soon as the physician or health care facility realize parents are likely to refuse a child's life or health saving treatment. See MHA Form 5-2, Release by Closest Relative Refusal of Treatment.

5.4 Refusal to Permit Blood Transfusion
As with any other treatment, a competent adult may refuse a blood transfusion. Refusal to permit a blood transfusion may occur for several reasons. The most commonly cited reason is that transfusion is against the religious beliefs of a patient of the Jehovah's Witness faith. In recent years Jehovah’s Witnesses have allowed administration of blood products but not whole blood. Of course, it is not the facility’s role to determine if a particular treatment is acceptable with respect to an individual’s religious beliefs. As with the case of refusal of any other substantial medical procedure, the refusal of blood must be an informed refusal. The patient's physician must explain why the transfusion is necessary. The reasons for the refusal should be
well-documented in the patient's medical record, and an incident report should be filled out in accordance with health care facility policy. Possible alternatives should be discussed. If the refusal is on religious grounds, this should be documented. Administration should be notified of the refusal. The refusal should be evidenced by an appropriate form. See MHA Form 5-3, Refusal to Permit Transfusion, and MHA Form 5-4, Refusal to Permit Transfusion (Jehovah's Witnesses).
CHAPTER 6 - LEAVING HEALTH CARE FACILITY AGAINST MEDICAL ADVICE, TEMPORARY ABSENCES, AND RESTRAINTS

6.1 Release from Facility Against Medical Advice

Regardless of the advisability from a medical standpoint of leaving an inpatient health care facility, a competent patient generally has an absolute right to leave. Forcibly detaining a competent patient would constitute false imprisonment. An exception to this general rule is the five-day period of involuntary detention allowed when an individual is voluntarily admitted to a mental health facility. Mont. Code Ann. § 53-21-111. See Chapter 10, Consent to Treatment for Mental Health Issues.

If facility personnel know or suspect a patient is planning to leave the health care facility against medical advice, the patient's physician should be contacted immediately, as the physician may be able to dissuade the patient from leaving. Regardless of whether or not the patient remains intent on leaving, the physician must attempt to thoroughly explain the risks of leaving against medical advice so that the patient’s decision to depart is an informed one. The patient’s expressed reasons for leaving, including healthcare risks entailed by early discharge, should be thoroughly documented in the patient's medical record.

If the physician cannot be reached before the patient’s departure, a provider familiar with the patient should discuss with the patient the patient's reasons for leaving.

6.2 Use of Written Forms

Health care facilities sometimes attempt to persuade a patient leaving the health care facility against medical advice to execute an acknowledgement form. See MHA Form 6-1, Acknowledgment of Release from Health Care Facility Against Medical Advice. The primary purpose of such a form is to document that the risks of leaving were explained to the patient. The patient’s reasons for leaving may also be documented on the form. Additionally, once the patient’s reasons for leaving become known, the health care facility may be able to address the patient's problems. Many forms concerning leaving the health care facility against advice contain a provision releasing the health care facility from liability that may occur as a result of leaving against advice. This provision may or may not have utility. It would appear counterproductive if its inclusion causes the patient to decline to sign the form.

6.3 Refusal to Sign

Regardless of whether it is believed the patient will sign it, the release form must, if possible, be offered to the patient, preferably in the presence of witnesses. The form should contain a notation that the patient refused to sign and be signed by the witnesses who were present. If the patient simply disappears from the health care facility or leaves before the physician or health care facility employees can discuss the matter with him or her, the health care facility is responsible for notifying the appropriate personnel. The patient's physician should be notified. Close family members should also be notified unless the patient has indicated they should not receive information. If the absence is unexplained and the patient is not immediately located, administration should consider whether it is advisable to notify law enforcement personnel.
6.4 Release by Another Against Medical Advice

On occasion, a parent or family member may demand that a minor or otherwise incompetent patient be released against medical advice. If the family member wishes the patient to be released and the patient wishes to remain, legal advice should be sought. If an adult patient’s wishes cannot be ascertained, or if he or she agrees with the family members (and the patient does not appear to be competent), the health care facility should give careful consideration to instituting guardianship proceedings on behalf of the patient.

If a parent demands the release of a minor patient against medical advice, the potential risk to the minor must be evaluated. If the risks are found to present a significant danger to the minor’s life or health, consideration should be given to applying for a court order to continue treatment. In any event, the person authorizing the release against medical advice of a minor or incompetent person must receive the same explanation of the risks involved that the patient would receive if he or she were competent. The same form should be used with appropriate notations made and signatures obtained as with an adult or competent patient. See MHA Form 6-1, Acknowledgment of Release from Health Care Facility Against Medical Advice.

6.5 Temporary Absence From Health Care Facility

A temporary absence is an absence that does not require readmission. Permission for temporary absence from the health care facility should always be obtained from the patient’s physician. If a temporary release is approved by the patient’s physician, the health care facility should determine what steps are needed to help prevent the patient from being harmed while absent. The health care facility should provide instructions for medication to be taken, appropriate activities, and, if applicable, ensure that the patient will be accompanied and that the patient’s physician be available as needed.

6.6 Restraints

Except for long-term care residents, Montana law does not set forth detailed requirements for patients in other facilities concerning consent to or refusal of restraints such as side bars. The facility’s policies may preclude restraints. If restraints are recommended, the informed consent or informed refusal of the patient or patient’s representative must be documented thoroughly.

For residents of long-term care facilities, use of restraints such as side rails is subject to strict regulation under Montana law. Mont. Code Ann. §§ 50-5-1201-1205; A.R.M. 37.106.2902-2905. Rules applicable to long-term care residents require written informed consent from the resident or the resident’s representative if the resident is incompetent. A.R.M. 37.106.2905(1). The consent form must:

- Document that the resident or the resident’s authorized representative was given a written explanation of the alternatives and any known risks associated with the restraint;
- Set forth any preexisting condition that may place the patient at risk of injury; and
- Contain written authorization from the resident’s primary physician that specifies the medical symptom the restraint is intended to address and the type of circumstances or duration under which it is to be used.
A.R.M. 37.106.2905(1).

Federal Medicare Conditions of Participation for Hospitals contain requirements for the use of restraints. 42 C.F.R. § 482.13. However, the Conditions of Participation do not require a special consent form that addresses restraints.
CHAPTER 7 - PREGNANCY AND CHILDBIRTH

7.1 In General
Obtaining and documenting informed consent for matters involving pregnancy and childbirth is particularly important. The cost of malpractice can be very high if an injured newborn must receive lifetime care and support. Furthermore, an expectant mother often has time in advance to consider treatment options she may want and make her preferences known. Parents must be informed of the purpose and limitations of any medical procedure in advance, and their must shall be documented.

7.2 Tests During Pregnancy

A. Standard Serological Tests
A physician or other person authorized to provide obstetrical care is required to take a blood sample for a standard serological test the first time a pregnant woman appears for prenatal care. Mont. Code Ann. § 50-19-103. A standard serological test means a test for syphilis, rubella immunity and blood group, including ABO (Landsteiner blood type designation - O, A, B, AB) and RH (Dd) type and a screening for hepatitis B surface antigen. Mont. Code Ann. § 50-19-101(3). Positive results for sexually transmitted diseases must be reported by the laboratory performing the tests to the Department of Public Health and Human Services (“DPHHS”) on forms provided by the DPHHS. Mont. Code Ann. § 50-19-105.

Despite the compulsory nature of the standard serological test, the purpose of the test must be disclosed to the patient. A serological test is required unless the pregnant woman has obtained a waiver from the district court for the reason that the tests are contrary to her religious creed. Mont. Code Ann. § 50-19-109. If a physician fails to request a blood sample from a pregnant woman, he or she may be guilty of a misdemeanor. However, if the physician requests a blood sample and that request is denied by the patient, the physician cannot be found guilty of a misdemeanor. Mont. Code Ann. § 50-19-103(4).

B. Amniocentesis
Amniocentesis tests amniotic fluid to detect the presence of genetic abnormalities including Downs Syndrome and Tay-Sachs Disease. It is usually recommended for women over age 35, women with a history of multiple miscarriages, or women with a genetic history that puts them at risk. Since amniocentesis involves obtaining a sample of amniotic fluid, it does contain some risk to the woman and fetus, and informed consent must be obtained. See MHA Form 7-1, Consent to Amniocentesis.

7.3 Newborn Screening Tests In General
Montana law requires two types of newborn screening tests which a health care facility is required to administer: metabolic tests and a hearing screening.

A. Metabolic and Genetic Testing

In Montana, newborn infants must be tested for certain inborn metabolic and genetic disorders. Mont. Code Ann. § 50-19-203. Heelstick tests are used to screen the newborn for the following disorders:

- Acylcarnitine disorders;
- Amino Acid disorders, including Phenylketonuria;
- Biotinidase deficiency;
- Classical galactosemia;
- Congenital adrenal hyperplasia;
- Congenital hypothyroidism;
- Cystic fibrosis; and
- Hemoglobinopathies

A.R.M. 37.57.301(3).

The administrator of the birthing health care facility is responsible for making sure an adequate blood specimen is collected before the newborn is discharged. A.R.M. 37.57.320. The newborn’s record must appropriately reflect the date of the taking of the specimen and the results of the tests performed. A.R.M. 37.57.320(d). Unlike many states, Montana law does not provide an exception based on religious objection by the parents. While metabolic and genetic testing is required by Montana law, in the event a parent does refuse to consent to metabolic and genetic testing of a child, the health care facility should, at a minimum, obtain a refusal to consent form. See MHA Form 7-2, Parental Acknowledgment – Refusal of Newborn Metabolic and Genetic Testing. The health care facility’s legal counsel should be consulted in the event the newborn’s parents refuse to allow the tests.

Montana administrative rules set forth required procedures for newborn metabolic tests (as well as required newborn eye treatment.) A.R.M. 37.57.301, 37.57.304, 37.57.305, 37.57.316, 37.57.320, 37.57.321.

B. Newborn Hearing Screening

Montana statute requires health care facilities that provide obstetrical care to administer a hearing screening to newborns. Mont. Code Ann. § 53-19-402. The testing can usually be done while the baby is asleep. As of 2008, all newborns must be administered a hearing screening by the health care facility prior to discharge. Additionally, the facility is required to provide education concerning the importance of hearing screening. Mont. Code Ann. § 53-19-404(1). See MHA Form 7-3, Consent to Newborn Hearing Screening. In the event a parent refuses to consent to the newborn hearing screening, DPHHS requires the health care facility to obtain the parent’s signature on a form substantially similar to
Health care facilities that provide obstetric care are required to report monthly to DPHHS:

(i) the infants born in the hospital or born outside of the hospital and transported or transferred to the hospital or health care facility;
(ii) the infants screened, including those infants born outside of the hospital or health care facility and transported or transferred to it from another hospital or health care facility or screened as part of a cooperative agreement with health care providers providing obstetric services in their service area;
(iii) the infants not screened and the reason each infant was not screened, in accordance with reporting requirements;
(iv) the infants who passed the screening; and
(v) the infants who do not pass their screenings and the contact information for the primary care provider who was notified of the screening results for each infant who did not pass the screenings.


7.4 Consent to Maternity Care

It is important (and expected) that the obstetrician explain to the expectant mother the various treatment options in maternity care. It is also important that the patient’s consent to maternity care be well documented. This must include consent to undergo additional procedures if necessary. If a true emergency occurs during labor or childbirth and the mother is unable to consent, implied consent under the emergency doctrine applies. A “Consent to Maternity Care” form documents the informed consent of the expectant mother. It is also an appropriate place to note any limitations on the treatment to which the expectant mother has consented. See MHA Form 7-5, Consent to Maternity Care, and MHA Form 7-6, Consent to Circumcision of Expected Child. If the health care facility takes photographs of newborns, an authorization should be obtained before the photographs are taken. The authorization should set forth the intended use of the photographs (e.g. possible sale to parents, posting on a web newborn “album,” testing or researching.) In addition, the facility must document in advance the expected mother’s wishes concerning family or friends that may be present during delivery.

7.5 Safe Haven Newborn Protection Act

Under Montana law, a parent who surrenders a newborn infant to a hospital or to law enforcement or fire protection personnel, cannot be charged with child abuse and neglect simply because they surrenders the infant. Mont. Code Ann. § 40-6-417. Note that this law, Montana Safe Haven Newborn Protection Act, Montana Code Annotated Title 40, chapter 6, part 4, does not provide protection with respect to health care facilities other than hospitals. A “newborn” is an infant a physician reasonably believes is not more than 30 days old. Mont. Code Ann. § 40-6-402(10). If other abuse or neglect occurred prior to the infant’s surrender, the parent may be criminally charged for the prior abuse or neglect.
Hospital personnel are required to comply with the provisions of the Montana Safe Haven Newborn Protection Act. Mont. Code Ann. § 40-6-405. The hospital must:

(a) Accept the newborn;
(b) If possible, inform the parent that by surrendering the newborn, the parent is releasing the newborn to DPHHS to be placed for adoption;
(c) If possible, inform the parent that the parent has 60 days to petition the court to regain custody of the newborn;
(d) If possible, ascertain whether the newborn has a tribal affiliation and, if so, ascertain relevant information pertaining to any Indian heritage of the newborn; and
(e) Provide the parent with written material approved or provided by DPHHS concerning the parent’s rights.

Mont. Code Ann. § 40-6-405(1), (2).

After giving the parent the required written DPHHS information, the hospital must:

(a) Encourage the parent to provide any relevant family or medical information, including information regarding any tribal affiliation;
(b) Provide the parent with information so the parent may seek counseling;
(c) Inform the parent that the information the parent provides will not be made public;
(d) Ask the parent for the parent’s name;
(e) Inform the parent that in order to place the newborn for adoption, the state is required to make a reasonable attempt to identify the other parent and to obtain relevant family medical information and then ask the parent to identify the other parent;
(f) Inform the parent that DPHHS can provide confidential services to the parent; and
(g) Inform the parent that the parent may sign a relinquishment for the newborn to be used at a hearing to terminate parental rights.

Mont. Code Ann. § 40-6-405(3).

A hospital is required to accept a newborn infant whether surrendered directly by the parent, or brought to the hospital after being left with law enforcement or firefighting personnel. Mont. Code Ann. § 40-6-406(1).

The hospital must have the newborn examined by a physician. If the physician determines the infant is more than 30 days old or there is reason to suspect additional abuse and neglect, a child abuse report must be made immediately pursuant to Montana Code Annotated § 41-3-201. Mont. Code Ann. § 40-6-406(2).

If the physician believes the infant is a newborn that has not suffered additional abuse and neglect, he or she must notify DPHHS no later than the first business day after receiving the newborn. Mont. Code Ann. § 40-6-406(3).
Under many circumstances, the hospital will not be able to obtain all (or any) of the information requested from the parent under the Montana Safe Haven Newborn Protection Act. To minimize potential liability under difficult circumstances, the Act provides:

A hospital and the agents and employees of the hospital are immune in a civil action for damages for an act or omission in accepting or transferring a newborn under this part, [Montana Safe Haven Newborn Protection Act] except for an act or omission constituting gross negligence or willful or wanton misconduct.

Mont. Code Ann. § 40-6-403(3).

DPHHS must reimburse the hospital for expenses incurred in accepting and caring for an infant surrendered under the Montana Safe Haven Newborn Protection Act. Mont. Code Ann. § 40-6-416.

7.6 Adoption and Related Issues
Hospitals may be presented with a variety of situations relating to adoptions. While the intricacies of the adoption process are not specifically a concern of the health care facility, certain issues may arise which require a determination by the health care facility of how to proceed with the treatment of a pregnant woman and the newborn child.

A. Timing of an Adoption
In Montana, a parent cannot voluntarily consent to the adoption of a child until the child is born and not less than 72 hours have elapsed since the birth of the child. Additional limitations, such as requiring counseling of the parent and preplacement evaluation of the adoptive parent(s), apply to when a parent can consent to an adoption. For purposes of the treatment of the newborn, all parental rights remain with the birth parent unless and until appropriate forms are obtained, as discussed herein. Mont. Code Ann. § 42-2-408.

B. Adoption Agencies
Only licensed adoption agencies may facilitate a private adoption of a child. Therefore, neither staff nor providers working at a health care facility should refer patients to anyone except a licensed adoption agency or an appropriate governmental agency, such as the Department of Public Health and Human Services, for purposes of assisting with the adoption process. See Montana Department of Social and Rehabilitation Services v. Angel (1978), 176 Mont. 293, 577 P.2d 1223.

C. Release of a Newborn to Adoptive Parents
In the event a newborn is to be adopted, the health care facility should insist upon receiving appropriate legal documentation from the birth parent prior to releasing a newborn to any individual other than the birth parent or legal guardian. After the initial 72-hour period, a legal parent may consent to the adoption of the child and relinquish his or her parental rights. Such forms are legal in nature and
should not be provided by the health care facility. Specifically, Montana law imposes the following requirements on consent and relinquishment forms:

(1) A relinquishment and consent to adopt must be in writing and must contain:

(a) the date, place, and time of the execution of relinquishment and consent to adopt;

(b) the name, date of birth, and current mailing address of the individual executing the relinquishment and consent to adopt;

(c) the date of birth and the name of the child to be adopted; and

(d) the name, address, and telephone numbers of the department or agency to which the child is being relinquished or the name, address, and telephone numbers of the prospective adoptive parent with whom the individual executing the relinquishment and consent has placed or intends to place the child for adoption.

(2) A relinquishment and consent to adopt executed by a parent or guardian must state that the parent or guardian executing the document is voluntarily and unequivocally consenting to the:

(a) permanent transfer of legal and physical custody of the child to the department or agency for the purposes of adoption; or

(b) transfer of permanent legal and physical custody to, and the adoption of the child by, a specific identified adoptive parent whom the parent or guardian has selected.

(3) A relinquishment and consent to adopt must state:

(a) that after the document is signed or confirmed in substantial compliance with this section, it is final and, except under a circumstance stated in 42-2-411, may not be revoked or set aside for any reason, including the failure of an adoptive parent to permit the individual executing the relinquishment and consent to adopt to visit or communicate with the child;

(b) that the relinquishment will result in the extinguishment of all parental rights and obligations that the individual executing the relinquishment and consent to adopt has with respect to the child, except for arrearages of child support unless the arrearages are waived by the person to whom they are owed, and that the relinquishment will remain valid whether or not any agreement for visitation or communication with the child is later performed;
(c) that the individual executing the relinquishment and consent to adopt has:

(i) received a copy of the relinquishment and consent to adopt;

(ii) received a copy of a written agreement by the department, agency, or prospective adoptive parent to accept temporary custody and to provide support and care to the child until an adoption petition is granted or denied;

(iii) if required, received counseling services pursuant to 42-2-409 explaining the meaning and consequences of an adoption;

(d) in direct parental placement adoptions, that the individual has:

(i) if a minor parent, been advised by a lawyer who is not representing the adoptive parent;

(ii) if an adult, been advised of the right to have a lawyer who is not representing the adoptive parent;

(iii) been advised that the attorney fees are allowable expenses that can be paid by the prospective adoptive parents; and

(iv) been provided with a copy of the prospective adoptive parent's preplacement evaluation;

(e) in agency and direct parental placement adoptions, that the individual has:

(i) been advised of the obligation to provide the medical and social history information required under 42-3-101 pertaining to disclosures; and

(ii) not received or been promised any money or anything of value for execution of the relinquishment and consent to adopt, except for payments authorized by 42-7-101 and 42-7-102.

(4) A relinquishment and consent to adopt may provide that the individual who is relinquishing waives notice of any proceeding for adoption.

Mont. Code Ann. § 42-2-412. In the event the relinquishing parent is a minor, the minor must be advised by an attorney prior to signing the relinquishment and consent forms. Mont. Code Ann. § 42-2-405.
A voluntary relinquishment is not valid unless the parent specifically relinquishes custody of the child to DPHHS, a licensed child-placing agency, or a specifically identified prospective adoptive parent and: (a) DPHHS or the agency to whom the child is being relinquished has agreed in writing to accept custody of the child until the child is adopted; or (b) the identified prospective adoptive parent has agreed in writing to accept temporary custody and to provide support and care to the child until that person's adoption petition is granted or denied. Mont. Code Ann. § 42-4-2-402. Therefore, a health care facility should require both the written consent and relinquishment forms from the parent and the written acceptance of custody and support by either a receiving agency or the adoptive parent(s). All such forms must be notarized. Mont. Code Ann. § 42-2-408. Unless a court orders otherwise to protect the welfare of the child, the relinquishment and consent to adopt entitles DPHHS, an adoption agency, or prospective adoptive parent named or described to the legal and physical custody of the child and imposes on DPHHS, the agency, or prospective adoptive parent responsibility for the support and medical and other care of the child. Mont. Code Ann. § 42-2-413(1).

An alternative to accepting the voluntary relinquishment and consent forms and an acceptance form from the adoptive parent(s), health care facilities may elect to only release a child to adoptive parents upon receipt of a temporary custody order from a court. Mont. Code Ann. § 42-4-111.

D. Surrogates
Several complexities may arise in the context of a surrogate birth mother. As a parent cannot legally consent to the relinquishment and adoption of a child until 72 hours after the child’s birth, all decisions regarding the health care of the parent and child remain with the birth parent until such time as the above-described adoption process is completed (i.e. execution of the relinquishment and consent forms and the written acceptance of custody and support of the adoptive parent(s)).

Issues concerning financial responsibility may also arise. Unless another individual agrees to be financially responsible for the patient, the birth mother remains responsible for any and all costs incurred at the health care facility. However, Montana law authorizes adoptive parent(s) to pay for certain fees incurred by birth parents, including fees associated with the adoption proceedings, prenatal care and medical care and services. A provider may receive or accept such payments from adoptive parents, but the payment may not be made contingent on the placement of a child for adoption or upon relinquishment of and consent to adoption of the child. In the event adoptive parent(s) indicate they will pay for medical costs associated with a surrogate mother’s delivery, such promises to pay must be in writing and signed by the individual(s) guaranteeing payment. Mont. Code Ann. § 42-7-101.
CHAPTER 8 - CONSENT FOR TREATMENT OF MINORS

8.1 Consent of Parents
A minor is an individual who is younger than 18 years old. Informed consent for treatment of a minor typically must be obtained from the minor’s parent or legally appointed guardian. An adoptive parent may consent to treatment of a minor. A stepparent may not consent to treatment of a minor; however, if faced with a potentially contentious stepparent, it may be advisable to obtain the consent of the stepparent in addition to the consent of the parent or legal guardian. Consent of both parents is not necessary. While a health care facility may create special forms evidencing consent to treatment of minors, it may be equally satisfactory if the parent or guardian (designated as such) signs the same type of consent form used to evidence informed consent of an adult. See MHA Form 3-1, Admission Consent Form, and MHA Form 8-1, Authorization to Treat Minor.

8.2 HIPAA and Minors
Rules adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, et seq. (“HIPAA Privacy Rule”) set federal standards for the control of health care information. Under the HIPAA Privacy Rule, if an individual has the right to consent to the health care treatment, the individual generally exercises control over that information. A parent or legal guardian usually has the right to make health care decisions for a minor child, so the parent or guardian controls the child’s health care information under the HIPAA Privacy Rule. 45 C.F.R. § 164.502(g)(3). For example, a parent or guardian may acknowledge receipt of the Notice of Privacy Practices, access the minor’s protected health information (PHI), and obtain an accounting of disclosures of PHI.

When a minor is emancipated according to state law, however, or when state law otherwise allows a minor to consent to or obtain health care, the minor and not the parent or guardian controls related PHI under HIPAA. 45 C.F.R. § 164.502(g)(3)(i)(A), (B).

In addition, if the parent or guardian agrees to confidentiality between the minor and a health care provider, the minor controls his or her PHI with respect to the applicable health care services. 45 C.F.R. § 164.502(g)(3)(i)(C).

Finally, the health care provider may elect not to permit the minor’s parent or guardian to control access to the minor’s health information if the provider reasonably believes the minor will be endangered or “has been or may be subjected to domestic violence, abuse or neglect by such person…” 45 C.F.R. § 164.502(g)(5).

When an individual is no longer a minor, the individual’s parents or guardian may no longer access the individual’s PHI, even for PHI that was created while the individual was still a minor.

8.3 Refusal of Parents to Consent to Treatment
Parents generally have the right to refuse medical treatment on behalf of their minor children. However, if the treatment proposed is likely to save the child’s life or health, courts
may be willing to intervene to require the treatment. The health care facility should establish a procedure in advance for applying for a court order of such treatment. Of course, legal counsel should be consulted as soon as the provider realizes parents are likely to refuse a child’s life- or health-saving treatment. Refusal of parents to consent to immunizations generally has specialized forms.

8.4 Absence of Parents
If both parents plan to be out of the country or will be otherwise difficult to contact for an extended period, they should consider signing a form, similar to a health care power of attorney, authorizing another person to consent to unexpected health care treatment. In the event there is not parent or legal guardian present for a minor and no health care power of attorney exists, the law in Montana is unclear as to whether a minor can consent to treatment or release from the facility, except as otherwise described in this Chapter. The hospital’s duty is to care for the patient. However, absent an emergency or potential life-threatening situation, the hospital must obtain consent or a refusal of consent from a parent or guardian, not a minor. Therefore, in the absence of parental or guardian consent or other circumstance described above, a health care facility should consult with counsel in these circumstances. If necessary, the matter may require court attention and potentially the appointment a guardian-ad-litem to act on behalf of the minor.

8.5 Disagreement Among Parents
Although only one parent may consent to treatment, if a minor’s parents do not agree on whether to consent to treatment, the health care provider should seek court guidance before proceeding with treatment.

8.6 Divorced Parents
When divorced parents have a minor child, Montana law requires that they have a court-ordered parenting plan that allocates parenting functions according to the child’s best interest. Generally, divorce does not change the fact that either parent may consent to health care treatment for a minor child. The parenting plan may contain specific requirements for consent to medical care and access to health care information. If a parent shows you a parenting plan with specific provisions concerning the minor’s treatment or access to the minor’s health care information, the parenting plan should be followed. The facility may consider requesting a copy of the relevant portions of a parenting plan, recognizing that the plan may be amended by the parents at a future time.

A natural parent whose parental rights have been terminated by court order cannot consent to medical treatment for a minor child. This is an exception to the general rule that either divorced parent may consent to medical treatment for a minor child.

The parenting plan may specify which parent must provide health insurance for the minor. Consent of the parent providing health insurance may also be advisable.

8.7 Foster Children and Children in Group Homes
If a minor in foster care or a group home requires non-emergency health care services, the health care provider should ask for a parental consent document or a court order that specifies
who may consent to the minor’s health care treatment. It would be prudent to obtain a copy of these documents for the patient’s medical file.

If a minor has been removed from his or her parents by an emergency protective order obtained under Montana Code Annotated Section 41-3-427, the parents generally must consent to the provision of health care services.

If a minor is in foster care because the State of Montana has temporary legal custody pursuant to Montana Code Annotated Section 41-3-442, the parents’ rights have not been terminated and parental consent is required unless a court order states otherwise.

If parental rights have been terminated and the State of Montana has permanent legal custody of the minor, a social worker generally consents to the minor’s medical treatment on behalf of the Department of Public Health and Human Services (“DPHHS”). A court order will specify that DPHHS may consent to medical treatment – ask to see it and, if possible, obtain a copy for the patient’s medical file.

8.8 When a Minor May Consent to Treatment
Montana statutes specify some circumstances under which a minor may consent to medical treatment. A minor who professes or is found to meet any of the descriptions discussed in the following paragraphs may consent to treatment. Since a minor may consent who professes to meet one of the following descriptions, a health care provider does not necessarily need absolute proof that the minor’s statements are accurate. However, in many instances, requiring verification of the minor’s status may be prudent. See MHA Form 8-2, Consent to Medical Services by Minor Authorized to Consent to Medical Treatment.

8.8.1 Marriage and Parenthood
A minor who is or has ever been married may consent to medical treatment. A minor who has a child may consent to medical treatment for her or himself and for the child. A minor may consent to health care treatment for his or her spouse if the spouse is unable to give consent by reason of physical or mental incapacity. Mont. Code Ann. § 41-1-402(4). If a minor claims to be married, consider requesting a copy of the marriage certificate.

8.8.2 Graduation From High School

8.8.3 Emancipation
A minor who has been separated from his or her parents or legal guardian for whatever reason and is supporting him- or herself may consent to medical treatment. Mont. Code Ann. § 41-1-402(2)(b). In addition, a minor may be granted the right to consent to medical treatment under to an order of limited emancipation granted by a court pursuant to Montana Code Annotated Section 41-3-438(3).
8.8.4 Emergency Treatment
A minor who needs emergency care, including transfusions, may consent to treatment, if his or her health will be jeopardized without such treatment. If emergency care is rendered, the parent or legal guardian must be informed as soon as practical. Mont. Code Ann. § 41-1-402.

8.8.5 Psychiatric or Psychological Counseling Under Urgent Circumstances
A minor may consent to psychiatric or psychological counseling by a physician or psychologist under circumstances when the need for such counseling is urgent in the opinion of the physician or psychologist involved because of danger to life, safety, or property of a minor or of other person or persons and the consent of the spouse, parent, custodian or guardian of the minor cannot be obtained within a reasonable time to offset the danger to life or safety. Mont. Code Ann. § 41-1-406.

8.8.6 Pregnancy, Reportable Communicable Disease (Including Sexually Transmitted Disease), or Drug or Substance Abuse (Including Alcohol)
A minor may consent to medical care for the prevention, diagnosis or treatment of pregnancy, a reportable communicable disease (including a sexually transmitted disease), or drug or substance abuse (including alcohol). The consent by a minor in the case of pregnancy, a sexually transmitted disease, or drug or substance abuse also obliges the health professional, if he or she accepts the responsibility for treatment, to counsel the minor, either personally or by referral to another health professional. Mont. Code Ann. § 41-1-402.


8.8.7 Financial Responsibility
A minor who gives valid consent to medical treatment cannot later revoke or disaffirm consent by reason of minority. Minors who consent to treatment are responsible for the cost of such treatment. If the minor is covered by health insurance, payment may be applied for services rendered. The parent, legal guardian or spouse of a consenting minor is not liable for payment unless such parent, spouse or legal guardian has expressly agreed to pay for such care. Mont. Code Ann. § 41-1-404.

8.8.8 Release of Information by Physician
Except for an emancipated minor, under certain circumstances, a health professional may, but is not obligated to, inform the parent, spouse or guardian of medical treatment given pursuant to the valid consent of a minor. Circumstances under which the treating health care professional may inform the parent, spouse, or guardian are:
(a) In the judgment of the health professional, severe complications are present or anticipated;
(b) Major surgery or prolonged hospitalization is needed;
(c) Failure to inform the parents, or legal guardian would seriously jeopardize the safety and health of the minor patient, younger siblings, or the public;
(d) To inform them would benefit the minor's physical or mental health and family harmony; or
(e) The hospital desires a third-party commitment to pay for services rendered or to be rendered.
(f) Regardless of the foregoing the minor is found not to be pregnant or not afflicted with a sexually transmitted disease or not suffering from drug or substance abuse, then no information with respect to any appointment, examination, test or other health procedure shall be given to the parents or legal guardian without the consent of the minor.


8.9 Consent For Mental Health Services
A minor at least 16 years of age may consent to voluntary admission to a mental health facility or treatment by a mental health professional or physician. Mont. Code Ann. § 53-21-112.

8.10 Use of Best Judgment
Montana statute provides that “[n]o physician, surgeon, dentist, or health or mental health care facility may be compelled against their best judgment to treat a minor on their own consent.” Mont. Code Ann. § 41-1-407. This provision merely codifies, with respect to consenting minors, the common law rule that a health care provider cannot be compelled to provide treatment against the provider's medical judgment.

8.11 Caveat
In addition to the statutes cited above, Montana has one other statute, Montana Code Annotated Section 41-1-405, addressing a minor's ability to consent to medical treatment. This statute is problematic for several reasons. It provides:

(1) A health professional may render or attempt to render emergency service or first aid, medical, surgical, dental or psychiatric treatment, without compensation, to any injured person or any person regardless of age who is in need of immediate health care when, in good faith, the professional believes that the giving of aid is the only alternative to probable death or serious physical or mental damage.

COMMENT: This provision allows health professionals to treat anyone without consent in an emergency if the health professional is not compensated. This is problematic, of course, because health professionals frequently should be
compensated for emergency care regardless of whether the patient is capable of consent. This provision should not be confused with “Good Samaritan” protection which provides for immunity from liability if emergency services are rendered without compensation.

(2) A health professional may render nonemergency services to minors for conditions that will endanger the health or life of the minor if services would be delayed by obtaining consent from spouse, parent, parents, or legal guardian.

COMMENT: This provision purports to distinguish emergency treatment from nonemergency treatment for conditions that will endanger life or health if consent is delayed. A condition that threatens life or health if consent is delayed would appear to constitute an emergency. At the least, the distinction is exceedingly fine.

(3) Consent may not be required of a minor who does not possess the mental capacity or who has a physical disability which renders the minor incapable of giving consent and who has no known relatives or legal guardians, if a physician determines the health service should be given.

COMMENT: For non-emergency treatment, it is inconceivable that a minor who is not capable of consent does not have someone responsible for making health care decisions, even if it is the State of Montana.

(4) Self-consent of minors does not apply to sterilization or abortion, except as provided in Title 50, chapter 20, part 2.

COMMENT: This provision is probably unconstitutional. For a more detailed discussion of consent issues relating to abortion, see Chapter 13.
CHAPTER 9 - INCOMPETENT OR INCAPACITATED INDIVIDUALS

9.1 Capacity to Give Informed Consent
In order to give informed consent, the individual must have sufficient understanding to make a rational decision concerning treatment. Competence is presumed unless evidence to the contrary becomes obvious or known. Lack of competence to consent may be temporary or permanent. Reasons for lack of competence to consent include unconsciousness, mental illness or deficiency, or the influence of drugs, including medications or alcohol. Sometimes it is easy to determine competence; at other times competence may be less clear-cut.

9.2 HIPAA and Incompetent or Incapacitated Individuals
The HIPAA Privacy Rule, 45 C.F.R. parts 160 and 164, provides that the person who has the right to consent to health care treatment for an individual generally exercises control over that individual’s protected health information (“PHI”) related to the treatment. Under the HIPAA Privacy Rule, the person who has authority under state law to make health care decisions for an incompetent or incapacitated individual is called the individual’s “personal representative.” 45 C.F.R. § 164.502(g)(2). Examples of personal representatives for an incompetent or incapacitated individual include a court-appointed guardian, as well as an individual named in a durable power of attorney for health care or other advance directive.

Some examples of actions a HIPAA personal representative may take on behalf of an incompetent or incapacitated individual are: accessing the individual’s PHI; signing authorizations; acknowledging receipt of the Notice of Privacy Practices; and obtaining an accounting of disclosures of PHI.

9.3 Individuals Adjudicated to be Incapacitated
A court may order a full or a limited guardianship for a person determined to be incapacitated. According to Montana statute:

An incapacitated person for whom a guardian has been appointed is not presumed to be incompetent and retains all legal and civil rights except those that have been expressly limited by court order or have been specifically granted to the guardian by the court.

Mont. Code Ann. § 72-5-306. The health care provider should keep a copy of the court order creating the guardianship in the individual’s health care records.

Full Guardianship: “A full guardian of an incapacitated person has the same powers, rights, and duties respecting the ward that a parent has respecting a minor child, except that a guardian is not liable to third persons for acts of the ward solely by reason of the parental relationship.” Mont. Code Ann. § 72-5-321(2). Unlike a parent, a guardian is not liable for the incompetent or incapacitated person’s health care treatment. Unless the guardian expressly agrees to be liable, payment for health care treatment must come from the resources available to the incapacitated person. In the case of a full guardianship, the guardian may generally give informed consent for the incapacitated person. According to Montana statute, unless limited by court order:
A full guardian may give any consents or approvals that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment, or service. This subsection (2)(c) does not authorize a full guardian to consent to the withholding or withdrawal of life-sustaining treatment or to a do not resuscitate order if the full guardian does not have authority to consent pursuant to the Montana Rights of the Terminally Ill Act, Title 50, chapter 9, or to the do not resuscitate provisions of Title 50, chapter 10. A full guardian may petition the court for authority to consent to the withholding or withdrawal of life-sustaining treatment or to a do not resuscitate order. The court may not grant that authority if it conflicts with the ward's wishes to the extent that those wishes can be determined. To determine the ward's wishes, the court shall determine by a preponderance of evidence if the ward's substituted judgment, as applied to the ward's current circumstances, conflicts with the withholding or withdrawal of life-sustaining treatment or a do not resuscitate order.

Mont. Code Ann. § 72-5-321(2)(c). Another exception to a full guardian's power to consent to treatment exists for treatment for a mental disorder. Montana Code Annotated Section 72-5-322 provides:

(1) If a guardian believes that the guardian’s ward should receive medical treatment for a mental disorder and the ward refuses, the court may, upon petition by the guardian, grant an order for evaluation or treatment. However, the order may not forcibly detain the ward against the ward’s will for more than 72 hours.

(2) The ward is entitled to an appointment of counsel and a hearing along with all the other rights guaranteed to a person with a mental disorder and who requires commitment under 53-21-114, 53-21-115, 53-21-119, and 53-21-120.

Limited Guardianship: If an incapacitated person is under a limited guardianship, the guardian's ability to consent to medical treatment is limited by the terms of the order appointing the guardian. The limited guardianship order will specify actions the limited guardian is authorized to take. These may include authority to:

[Provide timely and informed consent to necessary medical procedures and procedures implemented in connection with habilitation and training programs.


9.4 Individuals Not Adjudicated Incompetent or Incapacitated
At times, an individual who does not have a guardian or durable power of attorney for health care may appear marginally competent. If the individual’s close relatives agree to the treatment and if the treatment is clearly in the individual’s best interest, the attending physician
may reasonably determine sufficient informed consent exists. To forestall future problems, relatives involved in the individual’s treatment should also agree in writing to the treatment.

In the absence of a guardianship, the attending physician should initially determine if the individual is capable of giving informed consent. If the attending physician determines the individual is not capable of making his or her own health care decisions, first determine whether the individual has a durable power of attorney for health care or other valid advance directive. In the absence of any legal guardian or guiding documentation such as a durable power of attorney, the hospital should consider consulting one or more of the following:

1. Legal counsel;
2. Adult Protective Services;
3. Other relevant divisions of the Montana Department of Public Health and Human Services; and/or
4. County attorney’s office.

Depending on the specific situation, the county attorney may petition the district court to have a temporary or permanent guardian appointed for the patient.

9.5 Adults with Developmental Disabilities—Individuals in Group Homes

Residence in a group home does not automatically (or even usually) mean an individual does not have the capacity to make health care decisions. If the individual lacks capacity, he or she should have a guardian authorized to make health care decisions – ask to see the court order establishing the guardianship. The guardian may have previously authorized group home staff to consent to certain health care treatment on the guardian’s behalf; if this is the case, group home staff should provide a copy of the guardian’s written authorization.

Whether or not the individual is capable of consenting to health care treatment, the group home will often require PHI from a covered entity health care facility that treats the individual. If the group home is a covered entity under HIPAA, information can be shared among covered entities for treatment purposes. If the group home is not a covered entity, the safest course is to obtain a HIPAA-compliant authorization from the individual or the individual’s guardian authorizing the health care facility to share PHI with the group home. See Chapter 24, Authorizations.
CHAPTER 10 - CONSENT TO TREATMENT FOR MENTAL HEALTH ISSUES

10.1 In General
Like any other medical treatment, treatment for mental illness is subject to informed consent. For inpatient psychiatric services, consent must be obtained upon admission and also for the administration of any substantial treatment such as psychotropic medications. In general, even involuntarily committed patients have a constitutional right to refuse treatment. The fact that a patient is institutionalized for or on account of serious mental illness does not necessarily (or even usually) mean that the patient is incompetent for purposes of consenting to treatment. Statutes regulating treatment of the seriously mentally ill are found at Montana Code Annotated, Title 53, chapter 21, part 1. These statutes govern admission and discharge requirements and patient rights.

10.2 Voluntary Admission of Adults
An individual may apply for voluntary admission to a mental health facility. Montana Code Annotated Section 53-21-102(10), provides:

“Mental health facility” or “facility” means the state hospital, the Montana mental health nursing care center, or a hospital, a behavioral health inpatient facility, a mental health center, a residential treatment facility, or a residential treatment center licensed or certified by the department that provides treatment to children or adults with a mental disorder. A correctional institution or facility or jail is not a mental health facility within the meaning of this part.

Montana statute requires that application for admission to a mental health facility be in writing on a form prescribed by the facility. The application for admission form is not valid unless approved by a physician or certain other specified mental health professionals. Other mental health professionals that may approve the application for admission are specified at Montana Code Annotated Section 53-21-102(11). The person requesting voluntary admission must be given a copy of the consent form. It must contain a statement of the rights of the patient, including the right to release, and must be provided within 12 hours of admission. Mont. Code Ann. § 53-21-111. A patient applying for voluntary admission cannot be held for more than five days, excluding weekends and holidays, beyond the patient's written request for release. Mont. Code Ann. § 53-21-111(3).

10.3 Voluntary Admission of Minor; Consent by Minor to Outpatient Treatment
A minor who is at least 16 years of age may consent to mental health treatment in a mental health facility (except for a state institution) or from a physician or licensed mental health professional. Mont. Code Ann. § 53-21-112(1). For minors 15 years of age or younger, consent of a parent or guardian is also needed. Except for the fact that voluntary admission for minors under 15 must have the consent of a parent or guardian, the procedure for the voluntary admission of a minor to a mental health facility is the same as the procedure for voluntary admission provided by statute for adults. Mont. Code Ann. § 53-21-112(3).
10.4 Emergencies

Montana statute defines “emergency situation” as a situation in which any person is in imminent danger of death or bodily harm from the activity of a person who appears to be suffering from a mental disorder and appears to require commitment. Mont. Code Ann. § 53-21-102(7). A person whose behavior appears to create an emergency situation may be taken into custody by a peace officer only for a sufficient time to contact a mental health professional for an emergency evaluation. The mental health professional immediately makes an emergency evaluation and, if he or she determines that an emergency situation exists, the person may be detained and treated overnight. Mont. Code Ann. § 53-21-129. Detention for a longer period requires involuntary commitment proceedings.

If admitted to a mental health facility, a patient cannot be forced to consent to treatment except “during an emergency situation if the treatment is pursuant to or documented contemporaneously by the written order of a responsible mental health professional; or permitted under the applicable law in the case of a person committed to a facility by a court.” Mont. Code Ann. § 53-21-162(5)(c).

“Mental health professional” means a licensed physician, professional counselor, psychologist, social worker, or advanced practice registered nurse with a clinical specialty in psychiatric mental health nursing. Mont. Code Ann. § 53-21-102(11).

10.5 Involuntary Commitment; Mandatory Notification by Facility Prior to Release

Compliance with the legal requirements for involuntary commitment is beyond the scope of this Consent Manual. For matters related to involuntary commitment to a mental health facility, the advice of an attorney should be sought. The guardian of an incapacitated adult does not have the authority to consent to involuntary commitment. Instead, the statutory procedure for involuntary commitment set forth in Montana Code Annotated, Title 53, chapters 20 and 21, must be followed. Mont. Code Ann. § 72-5-321(5). Short of involuntary commitment, a guardian may petition the court for a mental illness evaluation or treatment of a ward, but the ward may not be held against the ward’s will for more than 72 hours. Mont. Code Ann. § 72-5-322. Where an individual has been committed involuntarily, the mental health facility must notify the court five days prior to the individual’s release. The court must then seal the records of the commitment proceedings. Mont. Code Ann. § 53-21-103.

10.6 Mandatory Reporting of Abuse and Neglect

With respect to patients of a mental health facility, “abuse” means:

Any willful, negligent, or reckless mental, physical, sexual or verbal mistreatment or maltreatment or misappropriation of personal property of any person receiving treatment in a mental health facility that insults the psychosocial, physical, or sexual integrity of any person receiving treatment in a mental health facility.


“Neglect” means:
Failure to provide for the biological and psychosocial needs of any person receiving treatment in a mental health facility, failure to report abuse, or failure to exercise supervisory responsibilities to protect patients from abuse and neglect. The term includes, but is not limited to: deprivation of food, shelter, appropriate clothing, nursing care, or other services; failure to follow a prescribed plan of care and treatment; or, failure to respond to a person in an emergency situation by indifference, carelessness or intention.


Any employee of the mental health facility with knowledge of an allegation of abuse or neglect must immediately report the allegation to the professional person in charge of the mental health facility. The person in charge of the facility must report the allegation in writing to the Montana Mental Disabilities Board of Visitors by the end of the next business day. If the allegation may constitute a criminal act, the person in charge of the facility must also immediately report the allegation to an appropriate law enforcement authority, such as the sheriff or county attorney. Mont. Code Ann. § 53-21-107(3).

The mental health facility is required to document its investigation into the allegation of abuse or neglect and to provide its report to the mental disabilities board of visitors and the director of the Montana Department of Public Health and Human Services within 5 working days of the completion of the investigation. Mont. Code Ann. § 53-21-107(7), (8).

10.7 Informed Consent to Medication and Other Treatment
Inpatient treatment for mental illness is another instance in which the law requires that informed consent be in writing. According to Montana statute, a patient admitted as an inpatient to a mental health facility has the right "not to receive treatment established pursuant to the [patient's] treatment plan in the absence of the patient's informed, voluntary and written consent to the treatment" except during an emergency situation. Mont. Code Ann. § 53-21-162(5)(c).

The administration of psychotropic drugs requires specialized consent and is not covered by a consent admission form. See MHA Form 10-1, Consent for Medications.

10.8 Release of Protected Health Information
Mental Health Protected Health Information ("PHI") is generally subject to the protections afforded to all PHI under HIPAA. Additional protections apply to psychotherapy notes. Psychotherapy notes are a narrow subset of mental health-related PHI, consisting of the mental health professional’s notes from counseling sessions.

Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record.
Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

45 C.F.R. § 164.501.

A covered entity may use or disclose psychotherapy notes, without obtaining authorization, in limited situations:

1. Use by the originator of the notes for treatment purposes;
2. Use or disclosure for the covered entity’s own training purposes for its staff; and
3. Use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual.

45 C.F.R. § 164.508(a)(2).

A mental health professional must generally obtain an authorization from the individual for use of psychotherapy notes by a person other than the person who created them. See Chapter 24, Authorizations.

An authorization to use or disclose psychotherapy notes cannot be combined with an authorization for other purposes. 45 C.F.R. § 164.508(b)(3)(ii).

Treatment or payment may not be conditioned on the use or disclosure of psychotherapy notes. 45 C.F.R. § 164.508(b)(4).

Disclosure pursuant to a valid authorization by a health care facility is permissive, not required. Psychotherapy notes are not part of an individual’s designated record set. Because they are not part of the designated record set, HIPAA does not contain a right of access by the individual to the individual’s psychotherapy notes. 45 C.F.R. § 164.524(a)(l)(i).

10.9 Mental Health Advance Directives

Montana law permits the use of a mental health advance directive for limited purposes. A mental health advance directive is used to allow an individual who episodically lacks capacity due to mental illness to specify in advance who must be notified and who may visit the individual when the individual lacks capacity and is being treated at a mental health facility. A mental health advance directive may be furnished to any inpatient mental health facility, whether or not the individual is currently admitted to the facility. The mental health advance directive is only effective if a mental health professional determines the individual lacks mental capacity to make or communicate decisions concerning the need for treatment. Mont. Code Ann. § 53-21-153. See MHA Form 10-2, Mental Health Advance Directive.
CHAPTER 11 - TRANSFUSIONS

11.1 In General
The issues of blood donation and transfusion have become of increasing concern since the advent of AIDS, SARS and West Nile Virus. It is highly important that an individual’s informed consent be obtained if the likelihood of need for a transfusion exists. If the likelihood of a transfusion is very remote, such transfusion, if required, may be consented to as part of a properly drafted consent to operation form (this form should include at least a reference to transfusions). See MHA Form 3-2, Consent to Operation and Other Medical Procedures. If the likelihood of a transfusion is greater than remote, a separate form probably should be required. The issue of refusal of a transfusion, including refusal on religious grounds, is covered at Chapter 5, Refusal to Consent to Treatment. See MHA Form 11-1, Consent to Blood Transfusion, and MHA Form 11-2, Consent to Autologous Transfusion.

11.2 Statutes Addressing Blood and Blood Products
Montana statute provides that furnishing blood is not considered a sale with respect to the health care provider furnishing it. Montana Code Annotated Section 50-33-102 provides:

**Furnishing of blood, blood products, and human tissue, organs, or bones declared service and not sale.** The furnishing of and the injecting, transfusing, transplanting, or transferring into the human body of whole blood, plasma, blood products, blood derivatives, human tissue, organs, or bones by a hospital, long-term care facility, or doctor of any such substances obtained from any source which said hospital, long-term care facility, or doctor is not directly or indirectly financially interested in or has any control over is hereby declared not to be a sale of such whole blood, plasma, blood products, blood derivatives, human tissue, organs, or bones for any purpose.

Since furnishing blood is not a sale, it is not subject to warranties that usually attach to the sale of products.

Montana also has a statute, found in a chapter addressing blood and blood products, purporting to grant immunity to physicians and hospitals. Montana Code Annotated Section 50-33-103 provides:

**Immunity of physicians and hospitals.** No physician, long-term care facility, or hospital may be held liable, in the absence of fault or negligence on the part of such a hospital, long-term care facility, or doctor, for injuries resulting from the furnishing or performing of such services.

This statute is intended to make clear that a provider performing a transfusion is not liable for an adverse outcome unless the provider is somehow at fault.

11.3 Required Reports For Adverse Events
Federal regulations for blood and blood components require donor and transfusion-related fatalities be reported to the Food and Drug Administration (FDA). 21 C.F.R. § 606.170(b). Donor reactions must be reported by the collecting facility and transfusion reactions must be reported by the facility that performed the compatibility tests. In 2003, the FDA published final, nonbinding guidance for notifying the FDA of fatalities related to blood collection or transfusion. These guidelines can be found at: http://www.fda.gov/BiologicsBloodVaccines/GuidanceComplianceRegulatoryInformation/Guidances/Blood/ucm074947.htm.(last visited February 11, 2010).
CHAPTER 12 - CONSENT TO STERILIZATION

12.1 In General
Although Montana statute does not require it, consent to sterilization should be in writing. Information provided in connection with obtaining informed consent should include:

1. Sterilization alternatives including forms of contraception.
2. Risks of the sterilization procedure.
3. Failure rates, including intrauterine and ectopic pregnancies. The success of the sterilization procedure should not be assured or guaranteed.
4. Feasible sterilization procedures for both men and women.
5. A description of the procedure contemplated.

12.2 Federal Funds
If federal funds (Medicaid) are to be used for the sterilization, a written consent form with certain elements is required by the federal government. A.R.M. 37.86.104; 42 C.F.R. §§ 441.252, 441.258. See MHA Form 12-1, Consent to Sterilization. Federal regulations require the patient’s written consent, at least 30 days but not more than 180 days prior to the procedure. 42 C.F.R. § 441.252. In addition to the federally required consent form, the physician may also wish to obtain a consent form for the procedure shortly before surgery. See MHA Form 3-3, Consent to Procedure. Federal funds cannot be used for sterilization of a person younger than 21 years old. 42 C.F.R. § 441.253.

12.3 Montana Statute Permits Health Care Facilities and Health Care Personnel to Refuse to Participate in Sterilization
Montana statute permits health care facilities and health care personnel to refuse to participate in sterilization. The refusal must be in writing, signed by the person refusing. The reason for the refusal may be grounds of “religious beliefs and moral convictions.” Mont. Code Ann. § 50-5-503(1). Montana Code Annotated, Title 50, chapter 5, part 5 addresses the right to refuse participation in sterilization. It is reproduced below in its entirety.

50-5-501. Definitions: As used in this part:
(1) “person” includes one or more individuals, partnerships, associations, and corporation;
(2) “sterilization” means the performance of, assistance or participation in the performance of, or submission to an act or operation intended to eliminate an individual's reproductive capacity.

50-5-502. Refusal by hospital or health care facility to participate in sterilization.(1) No private hospital or health care facility shall be required, contrary to the religious or moral tenets or the stated religious beliefs or moral convictions of such hospital or facility as stated by its governing body or board, to admit any person for the purpose of sterilization or to permit the use of its facilities for such purpose.
(2) Such refusal shall not give rise to liability of such hospital or health care facility or any personnel or agent or governing board thereof to any person for damages allegedly arising from such refusal or be the basis for any discriminatory, disciplinary, or other recriminatory action against such hospital or health care facility or any personnel, agent, or governing board thereof.

50-5-503. Refusal by individual to participate in sterilization. (1) All persons shall have the right to refuse to advise concerning, perform, assist, or participate in sterilization because of religious beliefs or moral convictions.

(2) If requested by any hospital or health care facility or person desiring sterilization, such refusal shall be in writing signed by the person refusing but may refer generally to the grounds of "religious beliefs and moral convictions".

(3) The refusal of any person to advise concerning, perform, assist, or participate in sterilization shall not be a consideration in respect of staff privileges of any hospital or health care facility or a basis for any discriminatory, disciplinary, or other recriminatory action against such person, nor shall such person be liable to any person for damages allegedly arising from refusal.

50-5-504. Unlawful to interfere with right of refusal. (1) It shall be unlawful to interfere or attempt to interfere with the right of refusal authorized by this part, whether by duress, coercion, or any other means.

(2) The person injured thereby shall be entitled to injunctive relief, when appropriate, and shall further be entitled to monetary damages for injuries suffered.

50-5-505. Refusal not grounds for loss of privileges, immunities, or public benefits. Such refusal by any hospital or health care facility or person shall not be grounds for loss of any privileges or immunities to which the granting of consent may otherwise be a condition precedent or for the loss of any public benefits.

COMMENT: The intent of this statute is to ensure a professional or facility does not run afoul of licensing authorities or reimbursement agencies.
CHAPTER 13 - ABORTION CONSENT ISSUES

13.1 Overview of the Law Governing Abortion

Although attempts will be made to keep the material contained in this Consent Manual up to date, it is well known that the law governing abortion is subject to constant probing and constitutional challenge. In the significant case of *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320, 126 S.Ct. 961 (2006), the United States Supreme Court reversed a decision which declared a New Hampshire law unconstitutional because it does not contain an exception to preserve the pregnant minor’s health if the minor seeks an abortion without informing her parents or seeking a judicial bypass. Instead, the Court held that a parental notification statute, on its face, was not unconstitutional. However, nothing in the Court’s decision was intended to preclude emergency procedures to protect the life of a minor. With respect to the subject of abortion, not only must a health care facility performing abortions for any reason have knowledge of current statutes and administrative regulations, it must be familiar with any recent case law interpreting those statutes and regulations.

13.2 Right to Refuse to Participate

The Montana Abortion Control Act provides that all private health care facilities and health care personnel have the right to refuse to participate in an abortion. *Mont Code Ann. § 50-20-111*. The constitutionality of this provision is not in question.

13.3 Montana Abortion Control Act

The Montana Abortion Control Act, Montana Code Annotated Title 50, chapter 20, part 1, and the accompanying Montana Parental Notice of Abortion Act, Montana Code Annotated, Title 50, chapter 20, part 2, have been the subject of several constitutional challenges. The Montana Abortion Control Act formerly prohibited a physician assistant from performing abortions. Although permissible under the United States Constitution, restricting a competent physician assistant was found to be an unreasonable restriction under the Montana Constitution. *Armstrong v. State*, 1999 MT 261, 296 Mont. 361, 989 P.2d 364. In 2005, the Montana legislature amended the Montana Abortion Control Act to comply with the *Armstrong* decision and permit physician assistants to perform abortions. *Mont. Code Ann. § 50-20-109(1)(a).*

The Montana Parental Notice of Abortion Act was held unconstitutional in the district court case of *Wicklund v. State*, Cause No. ADV-97-671 (Mont. 1st Jud. Dist. 1999). In *Wicklund*, the court enjoined the state of Montana from enforcing the Montana Parental Notice of Abortion Act, and the state did not appeal. Therefore, the injunction against the Montana Parental Notice of Abortion Act remains in place.

13.4 Informed Consent

The Montana Abortion Control Act specifies that informed consent to an abortion “must be certified by a written statement on a form prescribed by [the Department of Public Health and Human Services (“DPHHS”)]. . . .” *Mont. Code Ann., § 50-20-106(2).* However, DPHHS currently does not have a prescribed form. If DPHHS creates such a form, future versions of this Consent Manual will reflect those additions. Providers performing abortions should carefully develop an informed consent form taking into account the constitutional provisions of the Montana Abortion Control Act.
CHAPTER 14 - INMATES

14.1 In General
For health care providers, special considerations apply to persons in police custody and in correctional institutions. These include an inmate’s ability to consent to or refuse medical treatment, inmate rights with respect to protected health information (PHI), responsibility for payment for medical treatment of the inmate, and security measures taken in connection with an inmate.

14.2 Consent to or Refusal of Treatment
Inmates and persons in police custody have a constitutional right to adequate medical care. City of Revere v. Massachusetts Gen. Hosp., 463 U.S. 239, 103 S.Ct. 2979 (1983). An inmate or other detainee may also have a constitutional right to refuse medical treatment unless a compelling state interest outweighs the right to refuse. Singletary v. Costello, 665 S.2d 1099 (Fla. Dist. App 1996). Examples of a compelling state interest include preventing the spread of dangerous diseases and maintaining order in correctional facilities.

Inmates sometimes refuse food. Federal administrative regulations contain specific requirements for monitoring and treating inmate hunger strikers. 28 C.F.R. §§ 549.60-549.66.

Montana Code Annotated Section 50-18-108 authorizes testing and treatment of inmates for sexually transmitted diseases. The 2009 Montana Legislature revised Montana law to eliminate the exception to the informed consent laws as it relates to inmates. However, because such testing is still allowed under Montana Code Annotated Section 50-18-108, the health care facility should follow the same protocol for inmates as with other individuals, including the following to document an inmate’s treatment decisions:

- The facility should attempt to obtain informed consent from the inmate;
- Authorization for treatment from the correctional institution should also be documented;
- The inmate should receive pre-test and post-test counseling;
- If the inmate refuses to consent to treatment and the custodial agency represents treatment is necessary, the health care facility should request a copy of the legal authority that allows treatment (i.e. a statute or court order);
- Correctional institutions frequently enter into contracts with health care facilities to provide medical care to inmates. Procedures for obtaining inmate informed consent should be developed in advance in connection with such contracts. Contracts between the Montana Department of Corrections and health care facilities are public documents. They are available online at www.cor.mt.gov/.

14.3 Protected Health Information
The HIPAA Privacy Rule, 45 C.F.R. Parts 160 and 164, applies to inmates and correctional institutions. Under certain circumstances, a health care provider may disclose protected health information (PHI) to a correctional institution or a law enforcement officer that
has lawful custody of the inmate. Under these circumstances, the inmate’s authorization, a
subpoena, or other legal process is not required. HIPAA provisions governing inmates apply to
persons in custody who have been arrested but have not yet been charged with a crime, as well as
individuals in correctional institutions who have been charged or are serving their sentences. It
does not apply to individuals on parole or probation or who are otherwise not in lawful custody.

45 C.F.R. § 164.512(k)(5) sets forth the basic rule for disclosure of inmate PHI. To obtain PHI
without inmate authorization, subpoena, or other legal process, the correctional institution or law
enforcement official must represent to the health care provider that the health information is
necessary for one of the following reasons:

- The provision of health care to the inmate;
- The health and safety of the inmate or other inmates;
- The health and safety of the officers or employees of or others at the correctional
  institution;
- The health and safety of the inmate, other inmates, or those involved in
  transporting the inmate;
- Law enforcement on the premises of the correctional institution; or
- The administration and maintenance of the safety, security and good order of the
  correctional institution.

45 C.F.R. § 164.512(k)(5)(i).

See MHA Form 14-1, Release of Health Information Concerning Inmate or Other Person in
Lawful Custody.

The HIPAA Privacy Rule defines “inmate” and “correctional institution” broadly to include most
law enforcement custody situations. “Inmate” means a person incarcerated or otherwise
confined to a correctional institution. 45 C.F.R. § 164.501. “Correctional institution” means any
penal or correctional facility, jail, reformatory, detention center, workfarm, halfway house or
residential community program center operated by, or under contract to the United States, a state
or territory, a political subdivision of a state or territory, or an Indian tribe, for the confinement
or rehabilitation of persons charged with or convicted of a criminal offense or other persons held
in lawful custody. 45 C.F.R. § 164.501. “Other persons held in lawful custody” includes
juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons
committed to mental institutions through the criminal justice system, witnesses, or others
awaiting charges or trial. 45 C.F.R. § 164.501.

A correctional institution may or may not be a covered entity under HIPAA, depending on
whether it transmits electronic information and otherwise meets the definition of health care
provider (that is, it provides medical treatment or health care). 45 C.F.R. § 160.103. A large
correctional facility is likely to provide at least some health care; it may elect to be a hybrid
entity under HIPAA and segregate its health care functions from its other functions. 45 C.F.R. §
164.103. In addition to disclosure of PHI for one of the reasons applicable only to correctional
institutions under 45 C.F.R. § 164.512(k)(5), a correctional institution that is also a health care
provider may also receive PHI from and disclose PHI to another health care provider for
treatment purposes. A correctional institution that is a covered entity under HIPAA may use inmate PHI for any of the purposes, such as inmate treatment or safety of prison personnel, for which another covered entity may disclose PHI to the correctional institution. 45 C.F.R. § 164.512(k)(5)(ii).

The HIPAA Privacy Rule contains other provisions specific to inmates:

- **Notice of Privacy Practices:** A covered health care provider is not required to give an inmate a Notice of Privacy Practices, and a correctional institution that is a covered entity is not required to create a Notice of Privacy Practices. 45 C.F.R. § 164.520(a)(3).

- **Access to Protected Health Information:** An inmate has the same right as other individuals to access the inmate’s PHI, unless providing the PHI “would jeopardize the health, safety, security, custody or rehabilitation of the individual or other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for transporting of the inmate.” 45 C.F.R. § 164.524(a)(2)(ii). If a covered entity determines to deny an inmate’s request for PHI, the covered entity must give the inmate a written notice of denial within 60 days. The written notice must specify the basis for the denial. 45 C.F.R. § 164.524(d)(2).

- **Accounting of Disclosures.** An inmate does not have the right to receive an accounting of disclosures of PHI, if such disclosures are made to “correctional institutions or law enforcement officials as provided in § 164.512(k)(5).” 45 C.F.R. § 164.528(a)(1)(vii).

14.4 EMTALA

The Federal Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), 42 U.S.C. 1395dd, applies to inmates and individuals in law enforcement custody. EMTALA requires health care facilities with an emergency department to screen individuals presenting to the emergency room for an emergency medical condition and, if an emergency medical condition is present, to stabilize or transfer the individual.

14.5 Liability for Payment

If a court determines that an inmate has the ability to pay, the inmate will be held responsible for most medical costs, including those associated with pre-existing conditions and self-imposed injuries. In this situation, the health care facility must seek payment directly from the inmate. If an inmate does not have the ability to pay for medical costs, as determined by the court, the detention facility or county will be responsible for all of these costs. Mont. Code Ann. §§ 7-32-2242, 7-32-2245. If law enforcement authorities decline to arrest an individual to avoid liability for payment, the individual has the same rights with respect to PHI as any other individual. Declining to arrest to avoid payment would appear to expose the law enforcement authorities to potential liability under most circumstances.

14.6 Security
A health care facility may be liable for failing to ensure appropriate security measures are followed with respect to persons in custody. The health care facility may insist that law enforcement or correctional personnel provide appropriate security measures. Policies should be in place for determining the appropriate level of and providing security for persons in custody.
15.1 In General

In Montana, law enforcement officers must typically utilize an investigative subpoena to obtain protected health information (PHI) from a health care provider. Mont. Code Ann. § 46-4-301. An investigative subpoena will be signed by a district court judge and will specify the items or witnesses being subpoenaed. Law enforcement must show probable cause to obtain medical records and other health care information. Health care providers should comply with an investigative subpoena. Mont. Code Ann. § 46-4-301; 50-16-811(1)(i). Montana law is more stringent than the HIPAA Privacy Rule with respect to the disclosure of PHI to law enforcement. To the extent Montana law is more protective of health information than the Privacy Rule, Montana law continues to apply to protected health information. Such additional protection is not preempted under federal law. 45 C.F.R. §§ 160.202, 160.203. In 2003, when the Montana legislature made the Montana Uniform Health Care Information Act inapplicable to HIPAA-covered entities, it decided to retain a few of the Act’s more stringent provisions, including restrictions on the provision of health care information to law enforcement. The legislature adopted the Uniform Health Care Information Act’s provision concerning disclosure of information to law enforcement. Montana Code Annotated Section 50-16-805(2) provides:

A health care provider may disclose health care information about an individual for law enforcement purposes if the disclosure is to:

(a) federal, state, or local law enforcement authorities to the extent required by law; or

(b) a law enforcement officer about the general physical condition of a patient being treated in a health care facility if the patient was injured by the possible criminal act of another.

Therefore, unless another provision of law requires disclosure (such as pursuant to an investigative subpoena), Montana law does not allow disclosure of health care information for law enforcement purposes. An exception exists for the general physical condition of a crime victim. Mont. Code Ann. § 50-16-805(2)(b).

15.2 Blood Alcohol and Drug Tests

For law enforcement personnel to obtain the results of a blood test conducted by a hospital for medical treatment purposes (such as a routine blood test following an injury or accident), they must obtain an investigative subpoena. If an individual lawfully refuses a blood test requested for law enforcement purposes, the results of a blood test previously drawn for medical treatment purposes may be disclosed pursuant to an administrative subpoena. State ex rel. McGrath v. District Court, 2001 MT 305, 307 Mont. 491, 38 P.3d 820.

A physician, registered nurse or a qualified person acting under their supervision may conduct a blood test on an individual arrested for driving under the influence of alcohol or drugs at the request of a peace officer or the individual. However, if the individual
refuses consent to the test, the test may not be administered despite the peace officer’s request. Mont. Code Ann. § 61-8-402(4). Although not defined, “qualified person” probably means a person authorized to draw blood pursuant to the person’s professional scope of practice. The health care facility should obtain written informed consent for the blood test.

An individual who is unconscious is presumed to consent to the test. Mont. Code Ann. § 61-8-402(3). An arrested individual has the right to have a blood test even if the arresting officer has performed another test such as a breath test. If the arrested individual requests a blood test, the individual is responsible for paying for the test. Mont. Code Ann. § 61-8-405(2). If the subject of a blood test is a living person, the required procedure for collecting a blood sample for drug or alcohol analysis is set forth at A.R.M. 23.4.220. If the subject is deceased, the required procedure for collecting a blood sample is set forth at A.R.M. 23.4.221.

15.3 Required Reports to Law Enforcement Authorities
If disclosure of protected health information to law enforcement is required by another state or federal law, it may be disclosed. Mont. Code Ann. § 50-16-805(2). For instance, providers are required to report child and elder abuse and stab and gunshot wounds. See Chapter 26, Cases Requiring a Report to Law Enforcement or Health Authorities.

15.4 Homeland Security and Patriot Acts
The federal Homeland Security Act of 2002, Public Law 107-296 (November 25, 2002), and the USA Patriot Act, Public Law 107-56 (October 7, 2001), contain provisions pursuant to which a health care provider may be required to disclose protected health information. Such disclosures should be made promptly. However, the provider should first examine and copy appropriate identification for the officer making the request. Disclosures made pursuant to the Homeland Security and Patriot Acts must be recorded in the accounting of disclosures pursuant to 45 C.F.R. § 164.528. However, if the disclosure is made pursuant to national security activities authorized by the National Security Act, 50 U.S.C. 401, et seq., the disclosure need not be recorded in the accounting. 45 C.F.R. §§ 164.528(a)(1)(vii), 164.512(k)(2).

See MHA Form 15-1, Authorization of Test on Request of Law Enforcement Officer with Subject Consent.
CHAPTER 16 - SUBPOENAS AND COURT ORDERS

16.1 The Constitutional Issue

Even when a Montana statute or rule and the HIPAA Privacy Rule allow disclosure of protected health information (“PHI”), the information may be protected from disclosure the Montana Constitution. Unlike the United States Constitution, the Montana Constitution contains an express right of privacy. Article II, Section 10 of the Montana Constitution provides: “the right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest.” The Montana Supreme Court has held: “Medical records are private and deserve the utmost constitutional protection.” Henricksen v. State, 2004 MT 20, 319 Mont. 307, 84 P.3d 38.

As applied to the disclosure of health care information, Montana’s constitutional right to privacy continues to develop, and providers should be alert to changing interpretation by Montana courts. Health care providers, of course, do not evaluate court orders and subpoenas to determine whether they are constitutional. The provider should generally comply with a subpoena signed by a judge or a court order. A subpoena issued by an attorney should be examined to ensure it complies with applicable statutes and the HIPAA Privacy Rule.

Concerns about constitutional challenges to disclosure of health care information are avoided if the individual provides a HIPAA-compliant authorization clearly describing the information to be disclosed. For more on authorizations, see Chapter 24.

16.2 Montana Law and the HIPAA Privacy Rule

The HIPAA Privacy Rule allows disclosure of PHI when expressly ordered by a court or administrative tribunal. 45 C.F.R. § 164.512(e)(1)(i). Montana law adds a requirement that the order be for one of the reasons identified by statute. Montana Code Annotated Section 50-16-811(1) provides:

Health care information may not be disclosed by a health care provider pursuant to compulsory legal process or discovery in any judicial, legislative, or administrative proceeding unless:

(a) the patient has authorized in writing the release of the health care information in response to compulsory process or a discovery request;

(b) the patient has waived the right to claim confidentiality for the health care information sought;

(c) the patient is a party to the proceeding and has placed the patient's physical or mental condition in issue;

(d) the patient's physical or mental condition is relevant to the execution or witnessing of a will or other document;
(e) the physical or mental condition of a deceased patient is placed in issue by any person claiming or defending through or as a beneficiary of the patient;

(f) a patient's health care information is to be used in the patient's commitment proceeding;

(g) the health care information is for use in any law enforcement proceeding or investigation in which a health care provider is the subject or a party, except that health care information so obtained may not be used in any proceeding against the patient unless the matter relates to payment for the patient's health care or unless authorized under subsection (1)(i);

(h) a court has determined that particular health care information is subject to compulsory legal process or discovery because the party seeking the information has demonstrated that there is a compelling state interest that outweighs the patient's privacy interest; or

(i) the health care information is requested pursuant to an investigative subpoena issued under 46-4-301 or similar federal law.

16.3 Procedure for Obtaining Information
Montana statute sets forth specific requirements for obtaining PHI pursuant to a court order, subpoena or discovery (“compulsory process”). Mont. Code Ann. § 50-16-812. Significant points concerning the procedure for responding to compulsory process are:

- A HIPAA-compliant authorization is the best authority for providing protected health information pursuant to compulsory process. When the health of a party is an issue in a claim (such as for a plaintiff in a medical malpractice action) the party will almost always agree to provide an authorization for disclosure of necessary protected health information.

- All service of compulsory process (including court orders or discovery requests) must be accompanied by a written certification specifying the subsection of Montana Code Annnotated Section 50-16-811 that authorizes disclosure. Mont. Code Ann. § 50-16-812(2).

- In certain cases, the certification must state the individual or the individual’s attorney was served with a copy of the compulsory process or discovery at least 10 days before presenting the certificate to the health care provider. This gives the individual or attorney time to object to disclosure of the information. Mont. Code Ann. § 50-16-812(1). Ten days’ notice must be provided in the following situations:

  i. The patient has waived the right to claim confidentiality under Montana Code Annnotated Section 50-16-811(1)(b). This type of
waiver will seldom, if ever, occur. The official comments to
Montana Code Annotated Section 50-16-535, the statute from which
this provision is derived, give an example of waiver. In the example,
the individual has disclosed the PHI to a newspaper, thereby waiving
the right of privacy. Even if the “waiver” of newspaper disclosure
were valid under state law, the HIPAA Privacy Rule does not allow
disclosure just because the individual has made the information
public elsewhere. The HIPAA Privacy Rule preempts state law if
the Privacy Rule is more protective of the individual’s PHI.

ii. The individual’s physical or mental condition is relevant to the
execution of a will or other document. Mont. Code Ann. § 50-16-
811(1)(d).

iii. The physical or mental condition of a deceased person is placed at
issue by a person claiming or defending through or as a beneficiary

iv. For civil (not criminal) matters, when the court has determined a
compelling state interest outweighs the individual’s privacy interest.

• Even in instances where Montana Code Annotated Section 50-16-812(1) does not
require the certificate to state that 10 days’ notice has been given (i.e. for
subsections (c),(f),(g), and for criminal matters only, (h)), the HIPAA Privacy
Rule may require an attempt to notify the individual before disclosing the
information. The HIPAA Privacy Rule does not require an attempt to notify the
individual if the information is sought by means of a court-issued subpoena as
opposed to a subpoena generated by an attorney (but the certification requirement
However, if the information is not requested directly by a court, the HIPAA
Privacy Rule requires that the requesting party provide the health care provider
with “satisfactory assurances” that an attempt has been made to notify the
individual or that the party has sought a court order keeping the information
confidential. 45 C.F.R. § 164.512(e)(1)(ii)(vi).

• Montana statute sets forth a procedure by which a health care facility may object
to producing PHI pursuant to compulsory process. Mont. Code Ann. § 50-16-
812(4).

• The health care provider may charge a reasonable fee. Mont. Code Ann. §§ 50-
16-812(5), 50-16-816.

16.4 Workers’ Compensation
HIPAA defers to state law for disclosure of PHI for workers’ compensation purposes. 45
C.F.R. § 164.512(1). However, Montana workers’ compensation law is currently unsettled.
Montana statutes provide that by signing a claim for workers’ compensation, the claimant authorizes the workers’ compensation insurer to communicate with health care providers about the injury. Mont. Code Ann. §§ 50-16-527(5), 50-16-805(1). The communication may be informal, such as by telephone, and notice to the claimant is not required. Mont. Code Ann. § 50-16-527(5).

On October 19, 2005, the Montana Worker’s Compensation Court held unconstitutional the statutes allowing workers’ compensation insurers unlimited or informal communication with claimants’ health care providers. Thompson v. State, 2005 MTWCC 53 (2005). In Thompson, the court held the relevant statutes violate Montana’s constitutional right of privacy and due process guarantee. While acknowledging insurers do require claimants’ health care information, the court found the statutes’ blanket permission for insurers to communicate with providers was too broad. Specifically, the court found objectionable the provision authorizing communication between providers and insurers without giving the claimant an opportunity to be present, or an opportunity to object in advance to the scope of the disclosure. However, on appeal to the Montana Supreme Court, the Worker’s Compensation Court’s decision was vacated. Thompson v. State, 2007 MT 185, 338 Mont. 511, 167 P.3d 867. The Montana Supreme Court held that Worker’s Compensation Court did not have jurisdiction to hold the statutes unconstitutional. Therefore, the means and scope of communications between providers and worker’s compensation insurers remains as it is set forth in the statutes described above. Meanwhile, the safest method for insurers to obtain information concerning a workers’ compensation claim is to obtain a HIPAA-compliant authorization from the claimant. See Chapter 24, Authorizations.

16.5 Accounting of Disclosures
Disclosures of protected health care information pursuant to compulsory process must be recorded in the accounting of disclosures for the individual.
CHAPTER 17 - SUBSTANCE ABUSE PATIENT RECORDS

17.1 In General

Institutions conducting research or providing education, training, diagnosis, treatment, rehabilitation or referral with respect to drug and alcohol abuse are governed by federal regulations. 42 C.F.R. part 2 (“Part 2”). Records of the identity, diagnosis, prognosis or treatment of a patient maintained in connection with any alcohol abuse or drug abuse prevention function are protected by these regulations. Alcohol abuse or drug abuse prevention includes any program or activity relating to education, training, treatment, rehabilitation or referral. The term “program” includes formal drug abuse or alcohol abuse programs as well as persons and organizations performing the function of furnishing diagnosis, treatment or referral such as a general hospital treating patients for drug or alcohol abuse.

Mere reflection in the record that the patient has been diagnosed as an alcohol or drug abuser does not, without more, subject the record to Part 2. In addition, the diagnosis must be coupled with some alcohol abuse or drug abuse prevention function.

17.2 Part 2 and HIPAA

Organizations used to complying with Part 2 experience few difficulties in complying with the HIPAA Privacy Rule as well. However, where both the HIPAA Privacy Rule and Part 2 apply, all the requirements of both sets of regulations must be followed. The federal Substance Abuse and Mental Health Services Administration (“SAMHSA”) has made available a paper comparing Part 2 and HIPAA. “The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implication for Alcohol and Substance Abuse Programs.” http://www.hipaa.samhsa.gov/download2/SAMHSA%27sPart2-HIPAAComparisonClearedWordVersion.doc. (last visited February 16, 2010).

Consent under Part 2. Consent for disclosure of information pertaining to alcohol or drug abuse patient to persons other than the patient's attorney must be written and contain the following information:

- The name of the person/program making the disclosure.
- The name or title of the person or organization to which disclosure is to be made.
- The name of the client.
- The purpose or need for disclosure.
- The extent or nature of information to be disclosed.
- A statement that the consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon, and a specification of the date, event or condition upon which the consent will expire without express revocation.
- The date on which the consent is signed.
- The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient.
- The date on which the consent is signed.
• A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.
• The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

42 C.F.R. § 2.31. The regulations specify other categories of persons to whom limited disclosure of necessary information may be made without consent.

• Medical personnel to enable furnishing of services.
• Central registries concerning types of drugs and dosages and to prevent multiple enrollments.
• Patient's family unless disclosure would be harmful to the patient.
• Third party payers and funding sources only to the extent necessary to allow reimbursement.
• Employers and employment agencies for verification of status and treatment or where the information is necessary to evaluate hazards to the patient or others.
• Certain personnel in the criminal justice system where participation in a treatment program is a condition of the individual's release from confinement, suspension of sentence, etc.; with the patient’s consent, the scope of information related may be unrestricted.

If the matter involves a physician who is not a staff member, it should be referred to the hospital administrator, who should consult with the health care facility’s attorney to determine if disclosure of necessary information may be made without consent.

If a court order is served on the hospital, it should be complied with.

By telephoning the attorney for the party who secured the issuance of the court order, the health information manager may be able to make arrangements with the attorney which will avoid a considerable waste of time.

Instead of having the medical record administrator appear in court at the time specified in the court order, and then wait around for several hours or even days to be called as a witness, the attorney may agree to notify the medical record administrator by telephone as to when attendance as a witness will be actually required.
CHAPTER 18 - HIV AND AIDS

18.1 In General
Montana has an AIDS Prevention Act, Montana Code Annotated, Title 50, chapter 16, part 10. The express intent of the AIDS Prevention Act is to “treat AIDS, HIV-related conditions, and HIV infection in the same manner as other communicable diseases, including sexually transmitted diseases, by adopting the most currently accepted public health practices with regard to testing, reporting, partner notification, and disease intervention.” Mont. Code Ann. § 50-16-1004. The AIDS Prevention Act sets forth specific requirements for testing for HIV-related conditions, including provisions for counseling, encouraging partner notification and anonymous testing.

18.2 HIV-Related Test – Informed Consent
Except under very limited circumstances, the AIDS Prevention Act requires informed consent prior to an HIV test. While the Act no longer requires informed consent to be in writing, it is best practice to document the patient’s medical record that the patient was informed orally and/or in writing that HIV diagnostic testing will be performed. As discussed below, a separate consent form for HIV testing is no longer required under Montana law.

In 2009, the Montana Legislature substantially revised the AIDS Prevention Act, most notably in the areas of informed consent and pre-natal screening. Specifically, the Legislature added Montana Code Annotated Section 50-16-1014, which provides:

**Screening and pretest information.** (1) Screening for HIV-related conditions must be considered routine and must be incorporated into the patient's general informed consent for medical care on the same basis as other screening and diagnostic tests.

(2) Screening for HIV-related conditions must be voluntary and undertaken with the patient's knowledge and understanding that HIV diagnostic testing is planned.

(3) Patients must be informed orally or in writing that HIV diagnostic testing will be performed.

(4) If a patient declines an HIV diagnostic test, this decision must be documented in the patient's medical record.

The most significant statutory amendment is that facilities must incorporate HIV testing into a patient’s general consent form on the same basis as other screening and diagnostic tests. In essence, HIV testing no longer requires a special consent form and should be incorporated into a general consent form to encourage testing. Therefore, in the event a facility may administer any screening or diagnostic test, an addendum to the general informed consent form should be included which describes the tests to be performed. See MHA Form 18-1.

The definition of “informed consent” was also removed from the Act and is instead replaced by the general language of Section 50-16-1014(2) and (3). The Legislature also removed any reference to pre-test and post-test counseling, though such counseling requirements remain in
Montana regulations. Such counseling must still be offered and provided in a similar manner as with other testing and diagnostic procedures, as discussed below.

18.3 Pregnancy-Related Testing

The 2009 Legislative amendments also added significant emphasis to pre-natal and delivery testing for HIV. Montana law now allows for pre-natal testing for HIV in the same manner as with all other HIV testing as discussed above. Mont. Code Ann. § 50-16-1015. Additionally, physicians and other health care providers licensed to provide prenatal care to pregnant women may:

(a) offer an HIV diagnostic test in the third trimester to pregnant women who were not tested earlier in the pregnancy; and

(b) offer a repeat HIV diagnostic test in the third trimester of pregnancy, preferably before 36 weeks of gestation, to each of their pregnant patients at high risk for acquiring HIV-related conditions.

Mont. Code Ann. § 50-16-1015(5). If medically indicated, physicians and other health care providers licensed to provide prenatal care to pregnant women must:

(1) offer a rapid HIV diagnostic test to pregnant women in labor with unknown or undocumented HIV status;

(2) offer antiretroviral prophylaxis without waiting for the results of the confirmatory test if a rapid HIV diagnostic test or a standard HIV diagnostic test is positive.


18.4 Anonymous Testing

Montana law no longer requires health care providers to advise the patient about the availability of anonymous testing at certain locations around the state.

18.5 Disclosure of HIV Test Results

In general, the results of an HIV test may only be disclosed in the same manner and to the same individuals as with any other screening or diagnostic tests. The Montana legislature has essentially eliminated the distinction formerly contained in the statutes.

18.6 OSHA

The United States Department of Labor, Occupational Safety and Health Administration (OSHA), has promulgated mandatory regulations for occupational exposure to blood and other potentially infectious materials. 29 C.F.R. § 1910.1030. If an employee is potentially exposed to HIV/AIDS under the OSHA Guidelines, the employee must provide minimum necessary information about the “source individual.” This is an acceptable use of PHI under the HIPAA Privacy Rule. 45 C.F.R. § 164.512(b).
18.7 HIV/AIDS Specific Control Measures
Montana administrative rules set forth the measures that must be taken in connection with individuals with HIV or AIDS. These include: employing blood and body fluid precautions, A.R.M. 37.114.503(1), 37.114.101(1); counseling the individual about how to prevent spreading the HIV infection and what services may be available relevant to the individual’s health status, A.R.M. 37.114.503(3)(a),(b); and, locating and counseling the infected individual’s contacts. The health care provider must either interview the infected individual and notify the contacts, or request that the Department of Public Health and Human Services (“DPHHS”) do it. A.R.M. 37.114.503(4). Written materials may include the documentation provided by the Montana Department of Public Health and Human Services. The Department’s materials for a negative or a positive test are found at MHA Form 18-3, What Does it Mean?, and MHA Form 18-4, About Your Negative HIV Antibody Test.

18.8 HIV/AIDS Reporting Requirements
Montana administrative rules contain specific reporting requirements for HIV/AIDS. These reporting requirements have been revised and are now incorporated into the general disease reporting requirements. See Chapter 26, Cases Requiring a Report to Law Enforcement or Health Authorities.
CHAPTER 19 - PEER REVIEW AND QUALITY IMPROVEMENT PROTECTIONS

19.1 In General
Health care facilities engage in peer review and other quality improvement activities to monitor and enhance health care delivery. To encourage candid assessment of problems, limited legal protections exist for health care peer review and quality improvement activities. Peer Review/Quality Improvement protections fall into two categories:

1. Immunity from liability; and
2. Protection of information from discovery and use in court.

19.2 Immunity From Liability

19.2.1 Health Care Quality Improvement Act
The federal Health Care Quality Improvement Act of 1986 (HCQIA), 42 U.S.C. §§ 11101-11152, provides immunity from monetary damages for physician peer review actions taken by health care facilities, medical staffs, and other professional review bodies. To qualify for immunity, the reviewing entity must afford certain specific due process protections, such as adequate notice, the right to present and cross-examine witnesses, and the right to have a written record of the hearing. In addition, the review proceedings must be undertaken for the purpose of improving health care and not for economic or discriminatory purposes. HCQIA does not protect health care information from discovery or use in court.

19.2.2 Montana Statutes
Montana statute provides immunity from liability for individuals participating in peer review proceedings:

No member of a utilization review or medical ethics review committee of a hospital or long-term care facility or of a professional utilization committee, peer review committee, medical ethics review committee, or professional standards review committee of a society composed of persons licensed to practice a health care profession is liable in damages to any person for any action taken or recommendation made within the scope of the functions of the committee if the committee member acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts known to him after reasonable effort to obtain the facts of the matter for which the action is taken or a recommendation is made.

Immunity from peer review liability also extends to members, agents, or employees working for outside nonprofit peer review entities. Mont. Code Ann. § 37-2-201(3).

19.2.3 Use and Disclosure of Peer Review Information Under HIPAA

A covered health care facility may use or disclose PHI for peer review and quality improvement purposes. The HIPAA Privacy Rule, 45 C.F.R. parts 160 and 164, authorizes the use and disclosure of protected health information for the covered entity’s health care operations. 45 C.F.R. § 164.506. “Health care operations” is defined to include:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

* * * *

3. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.

45 C.F.R. § 164.501.

19.3 Protection From Discovery

In general, Montana statutes protect certain peer review and quality improvement information from discovery by third parties. In certain cases, PHI may not even be discoverable by the individual identified by the PHI. PHI must be used to make health care decisions about an individual to be available to the individual. If the PHI used solely for peer review or quality improvement purposes, it is usually protected from discovery. This could include Compliance Committee Activities. However, a bright line does not always exist separating discoverable from non-discoverable information.
**19.4 HIPAA Protections**

The HIPAA Privacy Rule specifies health care information that must be made available to the individual, regardless of the provisions of state law. This information is the individual’s “designated record set.” For an in-depth discussion of the HIPAA designated record set, see Chapter 23, Release to the Individual/Copying Costs. The designated record set includes all records maintained by or for the health care provider, that are “[u]sed in whole or in part, by or for the covered entity to make decisions about individuals.” 45 C.F.R. § 164.501. If information is used solely for peer review or quality assurance, it is probably not used to make decisions about the individual.

**19.5 Montana Statutory Protection**

The HIPAA Privacy Rule specifies the minimum amount of information that must be available to the individual (i.e., the designated record set). State law may allow the individual access to additional information.

For peer review and quality improvement purposes, the principal difference between the Privacy Rule and Montana law is, under Montana statute, incident reports and occurrence reports are clearly discoverable.

According to Montana statute:

> All data is confidential and is not discoverable or admissible in evidence in any judicial proceeding. However, this section does not affect the discoverability or admissibility in evidence of health care information that is not data as defined in § 50-16-201.


The definition of “data” is the key to determining whether information is protected.

> “Data” means written reports, notes, or records or oral reports or proceedings created by or at the request of a utilization review, peer review, medical ethics review, quality assurance, or quality improvement committee of a health care facility that are used exclusively in connection with quality assessment or improvement activities, including the professional training, supervision, or discipline of a medical practitioner by a health care facility.


“Data” does not include:

(i) Incident reports or occurrence reports; or
(ii) Health care information that is used in whole or in part to make decisions about an individual who is the subject of the health care information.
Montana statute defines incident reports and occurrence reports as follows:

“Incident reports” or “occurrence reports” means a written business record of a health care facility, created in response to an untoward event, such as a patient injury, adverse outcome, or interventional error, for the purpose of ensuring a prompt evaluation of the event.

The terms do not include any subsequent evaluation of the event in response to an incident report or occurrence report by a utilization review, peer review, medical ethics review, quality assurance, or quality improvement committee.

19.6 Additional Peer Review Protection
An additional Montana statute contains more, although perhaps redundant, protection from discovery for peer review activities. Unlike the statutes cited above, however, this statute contains a cross-reference to outside, non-profit peer review organizations. Mont. Code Ann. § 37-2-201(3). The statute provides:

The proceedings and records of professional utilization, peer review, medical ethics review, and professional standards review committees are not subject to discovery or introduction into evidence in any proceeding.

An unsettled question under Montana law is whether, or to what extent, statutory peer review protections apply to information supplied to outside peer review and quality assessment entities. Health care facilities should exercise particular caution in disclosing information to outside peer review or quality assessment entities.

19.7 Identification of Protected Information
A health care provider must ensure all protected or potentially protected peer review or quality improvement information is identified and appropriately secured. Minutes of meetings, records, reports and all other information within the definition of “data” under Montana Code Annotated § 50-16-201, should be appropriately labeled. An example of an appropriate label would be: “Privileged and Confidential Professional Review/Quality Assessment Material protected pursuant to Montana Code Annotated, Title 50, chapter 16, part 2 and Montana Code Annotated Section 37-2-201.”
CHAPTER 20 - ADVANCE DIRECTIVES

20.1 In General

“Advance directive” is a general term that describes health care instructions made by an individual to take effect during future periods of incompetence or incapacity. An advance directive may address only end-of-life decisions, or it may apply when an individual is not at the end of life but nonetheless is unable to make health care decisions. In Montana, the legal term for an end-of-life advance directive is a “declaration.” Declarations are governed by the Montana Rights of the Terminally Ill Act (“MRTIA”), Montana Code Annotated Title 50, Chapter 9.

20.2 MRTIA

The MRTIA sets forth a procedure by which an individual can consent in advance to the withholding or withdrawal of life-sustaining treatment in the event he or she is later unable to make such decisions. The MRTIA authorizes the use of the advance directives commonly referred to as living wills and health care proxies. The MRTIA also authorizes end-of-life decisions incorporated in a durable power of attorney for health care, if the statutory requirements for a declaration are contained in the document. See MHA Form 20-1, Declaration Made Pursuant to the Montana Rights of the Terminally Ill Act; MHA Form 20-2, Authorization for Another to Make Life Sustaining Treatment Decisions on My Behalf; and MHA Form 20-3, Declaration and Durable Power of Attorney for Health Care. The MRTIA contains sample language for a living will and a health care proxy. Mont. Code Ann. § 50-9-103(2). While use of the statutory language is not required, it should be included if possible to forestall questions of interpretation that may arise due to differences in terminology in non-conforming documents.

20.3 Advance Directives and HIPAA

For purposes of the HIPAA Privacy Rule, 45 C.F.R. parts 160 and 164, a person authorized to act on the individual’s behalf under state law may exercise that individual’s rights under the HIPAA Privacy Rule, 45 C.F.R. § 164.502(g). Therefore, if a valid Montana advance directive names another person to make health care decisions, that person may exercise the individual’s rights under the HIPAA Privacy Rule. For example, the person named in an advance directive to make health care decisions for the individual may acknowledge receipt of the Notice of Privacy Practices, authorize disclosure of protected health information (PHI), and obtain an accounting of disclosures of the individual’s PHI.

20.4 Requirements For a Declaration

The MRTIA contains certain requirements for the execution of a valid declaration governing end-of-life treatment decisions.

- The individual must be of sound mind and at least 18 years old. Mont. Code Ann. § 50-9-103(1). Minors may not execute advance directives. The MRTIA does not contain a provision allowing emancipated minors to execute a declaration.
- The individual must sign the advance directive in the presence of two witnesses. The witnesses must also sign the advance directive. The statute
contains no limitations on who may act as witnesses. However, it is probably desirable that the patient's physician and close family members decline to serve as witnesses unless no other witnesses are available.

20.5 Types of Declarations

- **Living Will.** A living will, called a “declaration” in the MRTIA, directs the health care provider to withhold or withdraw life-sustaining treatment in the event the patient has an incurable or irreversible condition. Life-sustaining treatment is treatment that only prolongs the dying process. It is not treatment that returns an individual to a functioning level, such as insulin for a diabetic patient. Life-sustaining treatment does not include treatment that is useful for the patient's comfort or to alleviate pain.

- **Health Care Proxy.** Another kind of declaration permitted under the MRTIA is a health care proxy. It is similar to a living will in that it only applies if the patient has an incurable or irreversible condition and is unable to make his or her own decisions. A health care proxy authorizes a person designated by the patient to make decisions concerning the withholding or withdrawal of life-sustaining treatment. The statutory language provides for backup living will provisions directing the withdrawal of life-sustaining treatment in the event the person nominated in the health care proxy is unwilling or unable to make these medical decisions. Health care proxies are fairly unusual; more often end-of-life decision making powers are included in the broader durable power of attorney for health care.

- **Durable Power of Attorney for Health Care.** The MRTIA contains only a brief cross-reference to durable powers of attorney for health care. **Mont. Code Ann. §§ 50-9-103(4), 72-5-501, 72-5-502.** Nonetheless, durable powers of attorney for health care are accepted as effective advance directives. See MHA Form 20-3, Declaration and Durable Power of Attorney for Health Care. A durable power of attorney for health care is effective any time the patient is unable to make his or her own health care decisions. This is different from a living will or a health care proxy which are only effective if the patient has an incurable or irreversible condition. A durable power of attorney for health care can be effective for decisions concerning life-sustaining treatment if it specifically states that it empowers the agent named by the individual to make decisions regarding the withholding or withdrawal of life-sustaining treatment. **Mont. Code Ann. § 50-9-103(4).**

Although it is sometimes recommended that an individual execute both a living will and a durable power of attorney for health care, great care must be taken to ensure that the provisions of the living will and the durable power of attorney for health care do not conflict. A living will commonly requires the health care provider to withhold treatment, whereas the durable power of attorney for health care entrusts total discretion with respect to withholding treatment to the designated individual. This may create a conflict with respect to the patient's wishes. If a living
will is desired in addition to a durable power of attorney for health care, the durable power of attorney for health care should probably expressly state that it does not apply to decisions concerning the withholding or withdrawal of life-sustaining treatment. However, it is usually easier to incorporate all of the patient's advance directives into one document. This can be accomplished by a durable power of attorney for health care that contains a provision authorizing the designated individual to make decisions with respect to the withholding or withdrawal of life sustaining treatment.

20.6 Revocation of Advance Directives
An individual may revoke his or her declaration concerning life-sustaining treatment at any time and in any manner without regard to mental or physical condition. Mont. Code Ann. § 50-9-104. That is, a revocation can be communicated in writing, orally or even by gesture. It is not necessary that the individual making the revocation be competent. Health care personnel or EMTs witnessing a revocation have an affirmative duty to communicate the revocation to the attending physician immediately. The revocation is then made part of the individual's medical record. It is recommended that in addition to noting the revocation in the medical record, the word “revoked” be placed prominently on the individual's advance directive. A revocation is also effective if it is communicated to a third person and the third person subsequently communicates the revocation to health care personnel.

An individual who is incompetent to make health care decisions may not execute an advance directive. However, just because an individual has a mental illness, developmental disability or other disability, does not necessarily mean the individual is not competent to make health care decisions. See Chapter 9, Incompetent or Incapacitated Individuals, and Chapter 10, Consent to Treatment for Mental Health Issues.

20.7 Responsibility of the Health Care Provider
A health care provider that is unwilling to honor an advance directive must attempt to transfer the patient to another health care provider that is willing to comply with the advance directive. Mont. Code Ann. § 50-9-203. Montana statute requires that a physician or other health care provider who is furnished a copy of an advance directive make it a part of the individual's medical record and, if the physician or health care provider is unwilling to comply with the advance directive, the individual must be advised immediately. Mont. Code Ann. § 50-9-103(5). The patient need not already have an incurable or irreversible condition for this requirement to apply. Since advance directives may take many forms, this provision requires health care facilities to scrutinize advance directives upon receipt in order to determine whether their provisions can be honored under the health care provider's policies. Depending on the variety of advance directives received, a burden could be placed on health care facility resources. If possible, however, efforts should be made to comply with this provision.

20.8 The Patient Self Determination Act
The federal Patient Self-Determination Act of 1990 ("PSDA"), 42 U.S.C. 1395cc(f), requires Medicare and Medicaid provider facilities to:

- Provide patients with written information concerning health care decision-making rights;
• Provide written information concerning the facility’s policies with respect to advance directives;
• Document in the patient’s medical record whether the patient has executed an advance directive;
• Comply with state law on advance directives; and
• Educate employees and the community about advance directives.

The PSDA applies to hospitals, skilled nursing facilities, home health agencies, HMOs and hospices. The information required by the PSDA must be provided as follows:

• Hospitals – at the time of admission as an inpatient;
• Skilled Nursing Facilities – at the time of admission as a resident;
• HMOs – before enrollment;
• Hospices – at the time of initial hospice care.

42 C.F.R. § 489.102(b).

If the individual is incapacitated at the time of admission, the information required by the PSDA must be given to the individual’s personal representative. 42 C.F.R. § 489.102(e).

For purposes of the PSDA, an “advance directive” is “a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.” 42 C.F.R. § 489.100.

Under the definition of advance directive set forth above, the PSDA applies to more than documents dealing with an individual’s end-of-life health care decisions. It also addresses Durable Powers of Attorney for Health Care regarding decisions that do not involve end-of-life treatment.

20.9 Nutrition and Hydration

An individual may make an advance directive declaration that expressly states the individual’s wishes concerning nutrition and hydration. More commonly, however, an advance directive contains statutory language directing the withholding or withdrawal of “treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.” Mont. Code Ann. § 50-9-103.

If an advance directive contains statutory language directive the withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary for comfort or to alleviate pain, nutrition and hydration may be appropriate under some circumstances. Nutrition and hydration must be administered, as appropriate, for comfort or to alleviate pain, but not if the treatment merely prolongs the process of dying. A declaration specifically addressing nutrition and hydration is provided in MHA Form 20-4, Declaration and Durable Power of Attorney for Health Care (Including Provisions on Nutrition and Hydration).
20.10 General Durable Powers of Attorney

Individuals often make “general” durable powers of attorney intended to allow the individual’s designated agent to engage in enumerated transactions on the individual’s behalf. Sometimes these general durable powers of attorney contain a “catch-all” authorization allowing the agent to “perform all acts I might perform.” Such a durable power of attorney is probably insufficient for health care purposes if it does not expressly authorize the agent to make health care decisions.

Sometimes a general durable power of attorney includes express authority to make health care decisions – this is acceptable. If the document is intended to apply to end-of-life decisions, as well as other health care decision, it must specifically state that it empowers the individual’s agent to make decisions regarding the withholding or withdrawal of life-sustaining treatment.

20.11 Do Not Resuscitate Notification, Comfort One, and Drivers’ Licenses

Montana statute authorizes the issuance of do-not-resuscitate (DNR) cards or bracelets directing emergency medical services personnel not to resuscitate an individual who has the appropriate identification. (“Comfort One” identification). Mont. Code Ann., Title 50, chapter 10; A.R.M. 37.10.101 et seq. Comfort One identification allows emergency medical personnel to ascertain immediately that an individual does not wish to be resuscitated. A commercially available “DNR bracelet” or the like is not a sufficient substitute for Comfort One identification. To qualify for Comfort One identification, an individual must either have a valid DNR, or a terminal illness and a declaration (living will). MHA has a complete explanation of Comfort One procedure on its website at www.mtha.org/comfort.htm. (last visited February 16, 2010).

In 2005, the Montana legislature amended the driver’s license statute concerning indications of the licensee’s intentions for life-sustaining treatment. As amended, Montana Code Annotated Section 61-5-301(b) provides that on each driver’s license, space must be provided to indicate whether the licensee has executed a declaration relating to the use of life-sustaining treatment.

20.12 Health Care Declaration Registry

The 2005 Montana legislature provided for the creation of a “Health Care Declaration Registry.” Mont. Code Ann. Title 50, chapter 9, part 5. The Montana Attorney General is required to accept end-of-life declarations made under the MRTIA for filing. The registry must be accessible by website and is required to have specific security levels to protect privacy. Health care providers are not required (but may) access the registry to determine if an individual has filed a declaration with the Attorney General. Mont. Code Ann. § 50-9-502(4). The Montana Attorney General intends to accept health care declarations beginning in 2006.

20.13 Advance Directive Declarations in Other States

The MRTIA provides that a declaration “executed in another state in a manner substantially similar” to Montana law and in compliance with the laws of the other state, is a valid declaration under Montana law. Mont. Code Ann. § 50-9-111. To avoid difficulties in interpreting the terminology of another state’s advance directive and determining whether it was executed in a “substantially similar” manner, it is preferable for individuals moving to Montana to execute a Montana advance directive.
20.14 Consent by Others to Withholding or Withdrawal of Treatment

If an individual is unable to make decisions regarding life-sustaining treatment and the individual has no valid advance directive, Montana statute authorizes certain relatives to consent to the withholding or withdrawal of treatment. Mont. Code Ann. § 50-9-106. This consent cannot be contrary to the known wishes of the individual. In order of priority, persons authorized to consent are:

(a) the spouse of the individual;
(b) the adult child of the individual or, if there is more than one adult child, a majority of the adult children who are reasonably available for consultation;
(c) the parents of the individual;
(d) an adult sibling of the individual or, if there is more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation; or
(e) the nearest other adult relative of the individual by blood or adoption who is reasonably available for consultation.

Mont. Code Ann. § 50-9-106(2). A full guardian may also consent or withhold consent under as provided in Montana Code Annotated Section 72-5-321.

A physician is not required to attempt to obtain the consent of others to the withholding or withdrawing of treatment; it is merely an option allowed to the physician. If the relatives in the category entitled to make the decision are evenly divided as to whether life-sustaining treatment should be withheld or withdrawn, the next class in order of priority is not permitted to act as a “tie-breaker” for purposes of making a decision. Mont. Code Ann. § 50-9-106(4). For example, if the two children of the individual disagree as to whether life-sustaining treatment should be withheld, the parent of the individual cannot be called upon to end the deadlock. In sum, the statute authorizing consent by others to withholding or withdrawal of treatment can provide assistance in the event an individual has no advance directive; however, it is no substitute for a properly executed advance directive.
CHAPTER 21 - PATIENT DEATHS AND AUTHORITY FOR AUTOPSY

21.1 Determination of Death
Montana statute provides that death has occurred under the following circumstances:

An individual who has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brainstem, is dead. A determination of death must be made in accordance with accepted medical standards.


If brain death has been determined in accordance with accepted medical standards, it is not necessary to secure the consent of the patient's relatives prior to disconnecting respiratory support systems because the patient is dead as a matter of law. The provisions of the Montana Rights of the Terminally Ill Act governing patient and relative permission to withhold or withdraw life sustaining treatment do not apply. However, the distinction between life maintained by respiratory support systems and brain death in which the deceased patient's circulatory system continues to function with artificial aid may not be clear to persons close to the patient. While consent to terminate support systems on the brain dead patient is not legally required, the process for determining brain death should be carefully explained to the deceased patient's family. The law considers the patient dead and consent is not legally required.

21.2 Protected Health Information of Deceased Individuals
HIPAA’s privacy provisions survive indefinitely after an individual’s death. 45 C.F.R. § 164.502(f). The HIPAA Privacy Rule defers to state law for determining who may exercise the HIPAA privacy rights of a decedent (deceased individual). 45 C.F.R. § 164.502(g)(4).

The federal HIPAA Privacy Rule and Montana statutes both use the term “personal representative,” but the term has different meanings under each. Montana law supercedes HIPAA. Under Montana law, a “personal representative” is the individual who administers a decedent’s estate under the Montana Probate Code. Mont. Code Ann. § 72-1-103(37). A Montana personal representative is appointed by a court to facilitate transfer of the decedent’s property. A decedent will need a personal representative only if the individual had property that needs to be probated. If there is a Montana personal representative, that person exercises the decedent’s health care privacy rights. Mont. Code Ann. § 50-16-804.

If there is no court-appointed “state law” personal representative, or the personal representative has finished administering the estate, Montana statute provides a list of persons authorized to act with respect to a decedent’s protected health information. These are: a surviving spouse, a parent, an adult child, an adult sibling, or any other person authorized by law to act for the deceased person. Mont. Code Ann. § 50-16-804.

21.3 Anatomical Gifts
Under Montana law, a hospital administrator is responsible for establishing a written organ donation protocol. Mont. Code Ann. § 50-5-212; A.R.M. 37.106.405. Montana has
adopted the Revised Uniform Anatomical Gift Act, Montana Code Annotated Title 72, Chapter 17. The Uniform Anatomical Gift Act sets forth procedures for consenting (and refusing) to make an anatomical gift. All Montana hospitals must establish agreements or affiliations with procurement organizations for coordination of procurement and use of anatomical gifts. Mont. Code Ann. § 72-17-108. The Act also requires specified family members to be consulted for consent to make an anatomical gift if there is no record that a potential donor consented to or refused to consent to make an anatomical gift.

A hospital, as soon as practical after the arrival of an individual reasonably believed to be dead or near death, shall make a reasonable search of the individual for a document of anatomical gift or other information identifying the bearer as a donor or as an individual who has refused to make an anatomical gift if there is not immediately available any other source of that information. Mont. Code Ann. § 72-17-213(3). Montana has a statewide organ and tissue donation registry. Mont. Code Ann. § 72-17-106. The registry requires anatomical gift information contained on individual drivers’ licenses to be transferred to the federally designated organ procurement organization for the region. Mont. Code Ann. § 72-17-106(1). An organ donation sticker on an individual’s drivers’ license is a legally sufficient document of anatomical gift. Mont. Code Ann. § 72-17-201(2)(a). If there is a valid document of anatomical gift, the donor’s family may not refuse to honor it. Mont. Code Ann. § 72-17-201(13).

If an anatomical gift document exists, consent by family members is not necessary. If no anatomical gift or refusal to make an anatomical gift can be found, persons close to the decedent may authorize an anatomical gift. The following priority applies with respect to persons permitted to make an anatomical gift on behalf of a decedent:

(a) an agent of the decedent at the time of death who could have made an anatomical gift under 72-17-201 immediately before the decedent's death (i.e. a parent of a deceased unemancipated minor or a power of attorney);
(b) the spouse of the decedent;
(c) an adult son or daughter of the decedent;
(d) either parent of the decedent;
(e) an adult brother or sister of the decedent;
(f) adult grandchildren of the decedent;
(g) a grandparent of the decedent;
(h) a guardian of the person of the decedent at the time of death; and
(i) any other person having the authority to dispose of the decedent's body.

Mont. Code Ann. § 72-17-214(1). If there is more than one member of a class listed above entitled to make an anatomical gift, an anatomical gift may be made by a member of the class unless that member knows of an objection by another member of the class. If an objection is known, the anatomical gift may be made only by a majority of the members of the class who are reasonably available. Mont. Code Ann. § 72-17-214(2). If a person in the class having priority or in a class having greater priority objects to the gift, the gift may not be made. Mont. Code Ann. § 72-17-214(3).

Entities that may receive anatomical gifts (donees) are, according to Montana statute:
(a) a hospital, surgeon, physician, or procurement organization, an accredited medical school, dental school, college, or university, or another appropriate person for education or research;

(b) an individual designated by the person making the anatomical gift if the individual is the recipient of the part; or

(c) an eye bank or tissue bank.


If a document of gift specifies only a general intent to make an anatomical gift, the gift may be used only for transplantation or therapy and the gift passes to the appropriate eye or tissue bank or the appropriate organ procurement organization. Mont. Code Ann. § 72-17-202(6)-(7). Additional protocols for organ and tissue donation are set forth in detail in the remaining portions of the Revised Uniform Anatomical Gift Act.

The HIPAA Privacy Rule provides that a health care provider may use or disclose protected health information to organ procurement organizations and similar entities. 45 C.F.R. § 164.512(h).

Sample forms authorizing an anatomical gift by the donor and by the members of the donor’s family having authority to make such gifts, are found at MHA Form 21-1, Anatomical Gift by Donor, and MHA Form 21-2, Anatomical Gift by Relative or Other Authorized Person.

21.4 Autopsy

Autopsies are used to determine or clarify the cause of death. They have a secondary purpose in that they are invaluable for medical education purposes. Depending on the circumstances of death, some autopsies are authorized by law. If an autopsy is authorized by law, consent of family members is not necessary. Consent by family members will be necessary if the autopsy is not required by the coroner, county attorney or attorney general. Mont. Code Ann. § 46-4-103(1).

According to Montana statute, the coroner is required to inquire into the following human deaths:

(1)(a) one that was caused or is suspected to have been caused in any degree by an injury, either recent or remote in origin; or
(b) by the deceased or any other person that was the result of an act or omission including but not limited to:
   (i) a criminal or suspected criminal act;
   (ii) a medically suspicious death, unusual death or death of unknown circumstances, including any fetal death;
   (iii) an accidental death; or
(c) by an agent, disease, or medical condition that poses a threat to public health;
(2) whenever the death occurred:
(a) while the deceased was incarcerated in a prison or jail or confined to a correctional or detention facility owned and operated by the state or a political subdivision of the state;
(b) while the deceased was in the custody of, or was being taken into the custody of, a law enforcement agency or a peace officer;
(c) during or as a result of the deceased's employment;
(d) less than 24 hours after the deceased was admitted to a medical facility or if the deceased was dead upon arrival at a medical facility; or
(e) in a manner that was unattended or unwitnessed and the deceased was not attended by a physician at any time in the 30 day period prior to death;
(3) if the dead human body is to be cremated or shipped into the state and lacks proper medical certification or burial or transmit permit; or,
(4) that occurred under suspicious circumstances.

Mont. Code Ann. § 46-4-122

All deaths occurring in a hospital under the possible circumstances outlined above must, of course, be reported to the coroner. The HIPAA Privacy Rule allows protected health information to be disclosed to a coroner or medical examiner for purposes of identifying the deceased person, determining the cause of death, or other duties authorized by law. 45 C.F.R. § 164.512(g)(1).

Unless an autopsy is specifically authorized by law or by the district court, an autopsy may be performed only by the decedent's written authorization or the authorization of the decedent's husband, wife or next of kin responsible by law for burial. Mont. Code Ann. § 50-21-103; see MHA Form 21-3, Authority for Autopsy.

21.5 Decisions Regarding the Disposition of a Body

In 2009, the Montana Legislature enacted the Montana Right of Disposition Act, Montana Code Annotated, Title 37, Chapter 19, Part 9. The Act provides additional guidance regarding disposition of the bodies of deceased individuals and protocols for resolving disputes. Unless otherwise specified in writing by the decedent, Montana law provides that the decedent’s relatives have the right to control disposition of the remains of the decedent and liability for the cost of the interment in the following order of priority, if the named person is 18 years of age or older and is of sound mind:

(a) a person designated by the decedent as the person with the right to control the decedent's disposition in an affidavit or written instrument executed in accordance with subsection Montana Code Annotated Section 37-19-904(1);

(b) the surviving spouse;

(c) the sole surviving child of the decedent or, if there is more than one child of the decedent, the majority of the surviving children. However, less than one-half of
the surviving children may be vested with the rights and duties provided in this section if those surviving children have used reasonable efforts to notify all other surviving children of their instructions and they are not aware of opposition to their instructions on the part of more than one-half of all surviving children.

(d) the surviving parent or parents of the decedent. If one of the surviving parents is absent, the remaining parent may be vested with the rights and duties provided in this section if that parent's reasonable efforts have been unsuccessful in locating the absent surviving parent.

(e) the surviving sibling of the decedent or, if there is more than one sibling of the decedent, the majority of the surviving siblings. However, less than one-half of the surviving siblings may be vested with the rights and duties provided in this section if those siblings have used reasonable efforts to notify all other surviving siblings of their instructions and they are not aware of any opposition to their instructions on the part of more than one-half of all surviving siblings.

(f) the surviving grandparent of the decedent or, if there is more than one surviving grandparent, the majority of the grandparents. However, less than one-half of the surviving grandparents may be vested with the rights and duties provided in this section if those grandparents have used reasonable efforts to notify all other surviving grandparents of their instructions and are not aware of any opposition to their instructions on the part of more than one-half of all surviving grandparents.

(g) the guardian of the decedent at the time of the decedent's death, if a guardian had been appointed;

(h) the personal representative of the estate of the decedent;

(i) the person in classes of the next degree of kinship, in descending order, under the laws of descent and distribution to inherit the estate of the decedent. If there is more than one person of the same degree, any person of that degree may exercise the right of disposition.

(j) if the disposition of the remains of the decedent is the responsibility of the state or a local government, the public officer, administrator, or employee responsible for arranging the disposition of the decedent's remains; and

(k) in the absence of any person listed above, any other person, including the mortician with custody of the remains, who is willing to assume the responsibility to act and arrange the disposition of the decedent's remains after attesting in writing that a good faith effort has been made to contact the individuals provided for above.

The liability for the reasonable cost of interment falls jointly and severally upon all kin of the
decedent listed above in the same degree of kindred and upon the estate of the decedent. Mont.
Code Ann. § 35-21-810(2). The priority sequence for such liability is the same as set forth above
concerning the right to control disposition of the remains of the decedent.

As set forth in the previous paragraph, the person having authority to control disposition of the
remains of the decedent has the authority to consent to an autopsy. The decedent's effects are
part of his or her estate. Under most circumstances, these can be released to the decedent's next
of kin or surviving spouse. If the personal effects are of great value and there is no surviving
spouse, they should be released only to the individual named as personal representative in the
decedent's will or the personal representative appointed by a court, if the decedent died without a
will. Regardless of who obtains the personal effects, the health care facility should require a
receipt.

Under appropriate circumstances, family members may take custody of a body rather than have
it sent to a mortuary. There are two important documents required in the process of removal and
disposition of a dead body.

One document is, of course, the death certificate. Providing information for the death certificate
and filing the death certificate with the local registrar is the responsibility of the person in charge
of disposition of the body. The person in charge of disposition of the body must present the
death certificate to the certifying physician, PA, APN or coroner for certification. Requirements
for the death certificate are found at Montana Code Annotated Section 50-15-403.

The other important document for release of a dead body is an authorization for removal of the
body, which must be prepared on a form provided by the Department of Public Health and

Montana Code Annotated Section 50-15-405 provides:

1) Except as provided in subsection (2), a dead body may be removed
from the place of death only upon the written authorization or oral
authorization, which must be reduced to writing within 24 hours, of the
physician in attendance at death or the physician’s designee, the advanced
practice registered nurse in attendance, the coroner having jurisdiction, or
a mortician licensed under 37-19-302.

2) If the death requires inquiry under 46-4-122, the written authorization
may only be granted by the coroner having jurisdiction or the coroner’s
designee or by the state medical examiner if the coroner fails to act.
However, when the only reason for inquiry under 46-4-122 is that the
body is to be cremated, the coroner may grant oral authorization for
cremation of the body, which must be reduced to writing as specified
under subsection (1) by the coroner.
(3) The written authorization to move a dead body, or when applicable, to cremate a dead body must be made in quadruplicate on a form provided by the department. The person in charge of the disposition of the dead body, the coroner having jurisdiction, and the local registrar must each be provided with and retain a copy of the authorization. A fourth copy may accompany the body to final disposition, as necessary.

(4) A written authorization issued under this section permits removal, transportation, and final disposition of a dead body.

A.R.M. 37.8.808 contains specific information that must be included in the authorization for the removal of a body form. The person in charge of disposition must send copies of the form to the local registrar within 48 hours of the body’s removal.

21.6 Definition of Person in Charge of Disposition
Montana statute defines “person in charge of disposition of a dead body” as:

A person who places or causes a dead body or the ashes after cremation to be placed in a grave, vault, urn, or other receptacle or otherwise disposes of the body or fetus and who is a funeral director licensed under Titles 37, chapter 19, an employee acting for a funeral director, or a person who first assumes custody of a dead body or fetus.


21.7 Transportation of the Body
A.R.M. 37.116.103 governs transportation of dead human bodies. Special rules apply for transportation of a body if the deceased had or was suspected of having an infectious disease listed in A.R.M. 37.116.102(3). If the deceased person did not have a listed disease, the body must be interred within 48 hours of death, or embalmed or refrigerated. A decedent’s family may take custody of the decedent’s body. After 48 hours, however, the body must be buried, brought to the crematorium, or delivered to a mortuary for refrigeration or embalming.

21.8 Final Disposition
The person in charge of disposition of the dead body is responsible for ensuring the final disposition of the body. According to Montana statute, “final disposition” means the burial, interment, cremation, removal from the state, or other authorized disposition of a dead body or fetus. Mont. Code Ann. § 50-15-101(7).

21.9 Cremation
Unlike burials, cremations may only be done by a licensed crematory. Mont. Code Ann. § 37-19-705(1). In addition, certain rules govern disposition of cremated remains. Mont. Code
Ann. § 37-19-706. **Caution:** As with other rules governing the disposition of dead bodies, this rule does not extend to Indian reservations.

**21.10 Role of Health Care Facility**
While the health care facility should insure that the authorization for the removal of a dead body is properly filled out and the person in charge of disposal has a death certificate signed by the appropriate party, it may not wish to provide formal advice with respect to disposition of the body. The health care facility should obtain a receipt for the body and any personal belongings.

**21.11 Application**
None of the provisions of this chapter concerning the disposition of dead bodies apply to Indian reservations.
CHAPTER 22 - RELEASE OF PROTECTED HEALTH INFORMATION UNDER HIPAA

22.1 Overview
A thorough discussion of the HIPAA Privacy Rule, 45 C.F.R. parts 160 and 164, is beyond the scope of this Consent Manual. The chapters that follow provide an overview of the Privacy Rule, especially with respect to Montana law and consent issues. Chapter 22 summarizes uses and disclosures for which an authorization is not required. Chapter 23 discusses the designated record set and the concept of the permissible copying costs. Chapter 24 sets forth required elements for a HIPAA-compliant authorization. Chapter 25 discusses HIPAA’s application to marketing activities.

22.2 The Constitutional Caveat
Even if allowed by the HIPAA Privacy Rule and any applicable Montana statutes and rules, disclosure of health care information may be found to violate Montana’s constitutional right to privacy. Mont. Const., Art. II, § 10. To withstand constitutional challenge, the rule must be narrowly tailored to serve a compelling state interest. Henricksen v. State, 2004 MT 20, 319 Mont. 307, 84 P.3d 38. Even if applicable law seems to permit disclosure, a provider may prefer to be conservative if the disclosure seems contrary to reasonable privacy expectations. It is unclear from Montana case law whether a violation of the right of privacy by a non-governmental entity can give rise to damages. The issue is currently pending in at least one district court case and may ultimately be decided by the Montana Supreme Court.

22.3 HIPAA and Disclosures
Most HIPAA Privacy Rule provisions that address basic disclosure of protected health information (“PHI”) do not need to be analyzed to determine whether they are preempted by Montana law. The 2003 Montana legislature amended the Montana Uniform Health Care Information Act, Title 50, chapter 16, part 5, Montana Code Annotated, to specify that it no longer applies to health care providers that are covered entities under the HIPAA Privacy Rule. Mont. Code Ann. § 50-16-505. The few provisions the legislature wished to retain for HIPAA covered entities are found at Title 50, chapter 16, part 8, Montana Code Annotated. The Montana Uniform Health Care Information Act continues to apply to health care providers that are not covered under the HIPAA Privacy Rule. It is permissible for a HIPAA covered entity to disclose PHI to and receive PHI from a non-covered entity for treatment purposes; the HIPAA Privacy Rule does not specify disclosures for treatment purpose must be made among covered entities.

22.4 Protected Health Information (“PHI”)
The HIPAA Privacy Rule only applies to protected Individually Identifiable Health Information. Individually Identifiable Health Information is information held or created by a covered entity that is likely to be able to identify the individual. More specifically, Individually Identifiable Health Information is limited to information which relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and either (i) That identifies the individual; or (ii) with respect to which there is a
reasonable basis to believe the information can be used to identify the individual. Most Individually Identified Health Information is PHI. 45 C.F.R. § 160.103.

22.5 Treatment, Payment and Health Care Operations
Most permitted uses and disclosures of PHI are for treatment, payment and health care operations. These uses and disclosures do not require the individual’s authorization. 45 C.F.R. § 164.506. Disclosures made for treatment, payment and health care operations are not subject to a right to an accounting pursuant to 45 C.F.R. § 164.528.

22.6 Minimum Necessary
For payment and health care operations, permissible use and disclosure is limited to the “minimum necessary” to accomplish the purpose. 45 C.F.R. § 164.502(b)(2)(i).

22.7 Disclosures Requiring an Opportunity for an Individual to Object
Directory information about an individual, such as name, location in the facility, religious affiliation and general health condition (i.e., good, fair, poor, serious, critical) may be disclosed without written authorization provided the individual is given an opportunity to object if the individual does not want the information disclosed. 45 C.F.R. § 164.510(a). In the event of an emergency, the information may be disclosed without an opportunity to object. 45 C.F.R. § 164.510(a)(3).

Provided the individual is given an opportunity to object, PHI may be disclosed to family or close personal friends provided the PHI is relevant to such person’s involvement with the patient’s care or for payment. 45 C.F.R. § 164.510(b).
CHAPTER 23 - RELEASE TO THE INDIVIDUAL/COPYING COSTS

23.1 The Designated Record Set

An individual generally has the right to access protected health information (“PHI”) contained in the individual’s designated record set. 45 C.F.R. § 164.524(a)(1). “Designated Record Set” is defined as:

(1) A group of records maintained by a covered entity that is:

   (i) the medical records and billing records about individuals maintained by or for a covered health care provider.
   (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
   (iii) used, in whole or in part, by or for the covered entity to make decisions about the individuals.

(2) For purposes of this paragraph, the term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used or disseminated by or for a covered entity.

45 C.F.R. § 164.501.

The key to determining if something is part of the designated record set is whether it is used, in whole or in part, to make decisions about the individual. Peer review and quality assurance data typically would be not part of the designated record set because such data is used to evaluate the provider, not to make decisions about the individual. The following are part of the designated record set:

- Medical records
- Claims adjudication information
- Patient account information
- Advance Directives
- PHI received from another provider. (Note: other providers’ records contained in the patient’s file are part of the designated record set unless they were not used at all to make decisions about the individual. For instance, records received from another provider by mistake and not reviewed by the necessary provider would not be part of the designated record set.)
- Diagnostic Films
- Electrocardiogram Tracings

23.2 Part of the Designated Record Set But Access May Be Denied
For certain documents, a provider may deny access to PHI in the individual’s designated record set. These include psychotherapy notes and information compiled for certain legal proceedings. 45 C.F.R. § 164.524(a)(1).

23.3 Time For Providing Access or Copies
Generally, the covered entity must act on an individual’s request to access PHI within 30 days. This period may be extended for an additional 30 days under certain circumstances. If the information is not maintained on-site, the provider has 60 days to respond. 45 C.F.R. § 164.524(b).

23.4 Copying Costs
Montana law allows providers to charge up to fifty cents per page, plus an administrative fee up to $15 for copying. Mont. Code Ann. § 50-16-816.

In cases where the individual requests the information (as opposed to providing an authorization to someone else), the HIPAA Privacy Rule limits copying costs to the actual cost of copying and labor to perform the copying (but not other overhead). 45 C.F.R. § 164.524(c)(4). Therefore, if the individual requests the information, the facility should not charge the $15.00 administrative fee and could be required to demonstrate the per-page fee which represents the actual cost of copying.
CHAPTER 24 – AUTHORIZATIONS

24.1 Use of Authorizations
When in doubt as to whether disclosure of protected health information (“PHI”) is permitted, obtaining a HIPAA-compliant authorization will eliminate uncertainty. As discussed in Chapter 16, Subpoenas and Court Orders, in the vast majority of cases, the relevant PHI is obtained by means of a HIPAA-compliant authorization. Uses and disclosures requiring an authorization, as well as the elements of a valid authorization, are found at § 164.508. An authorization is expressly required for specified uses, such as disclosure of psychotherapy notes and for marketing. § 164.508(a)(2), (3).

24.2 Elements of a Valid Authorization
A HIPAA-compliant authorization contains the following elements:

- a description of the PHI “that identifies the information in a specific and meaningful fashion.”
- the name or other specific identification of the person(s) authorized to disclose the PHI.
- the name or other specific identification of the persons to whom the PHI may be disclosed.
- a description of each purpose of the requested use or disclosure. “At the request of the individual” is a sufficient description if the individual initiates the request.
- an expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure
- signature and date.

§ 164.508(c)(1)(i)-(iv).

The authorization must also contain the required statements found at § 164.508(c)(2). These requirements include a statement about that the covered entity may not condition treatment on whether the individual signs the authorization. The individual is entitled to a copy of the authorization. § 164.508(c)(4).
CHAPTER 25 - USE OF PROTECTED HEALTH INFORMATION FOR RESEARCH

25.1 HIPAA and Montana Law

Even before the advent of the HIPAA Privacy Rule, consent and disclosure issues involving research were strictly regulated. Most research was (and is) subject to federal human subjects rules; specifically, the Common Rule, 45 C.F.R. part 46, subpart A, and FDA human subject protection regulations, 21 C.F.R. parts 50 and 56. The Montana Uniform Health Care Information Act did not allow disclosure of protected health information unless an institutional review board made certain findings with respect to the need for and protection of such information. Mont. Code Ann. § 50-16-529(6). The Montana statute addressing research no longer applies to HIPAA-covered entities. Therefore, a HIPAA-covered health care provider should look to the HIPAA Privacy Rule with respect to disclosure of protected health information (“PHI”) for research purposes. In one respect, the HIPAA Privacy Rule is more permissive than the formerly applicable Montana statute. According to the Montana statute, disclosure of protected health information without patient authorization had to be approved by an institutional review board. Mont. Code Ann. § 50-16-529(6). The HIPAA Privacy Rule allows approval for disclosure by either an institutional review board or a privacy board within the facility. 45 C.F.R. § 164.512(i).

25.2 Authorizations for Research

The HIPAA Privacy Rule allows for PHI to be used or disclosed for research purposes pursuant to an individual’s authorization. Generally, authorizations are appropriate for use of PHI for research unless obtaining the authorization is impracticable. For example, obtaining individual authorizations for records research may simply not be feasible, particularly if the PHI was generated a long time ago and/or the individuals are deceased. An authorization for research purposes must comply with the general authorization requirements of 45 C.F.R. § 164.508. A research authorization differs from other authorizations in that it is not required to specify an expiration date or event.

25.3 Use or Disclosure without an Authorization

Under the HIPAA Privacy Rule, an institutional review board or facility privacy board may waive the requirement for individual authorization for disclosure of PHI if certain conditions are met. 45 C.F.R. § 164.512(i). To approve a waiver, the institutional review board or privacy board must find that the use or disclosure of PHI involves no more than a minimal risk to the privacy of individuals, based on, at least, the presence of the following elements:

(1) An adequate plan to protect the identifiers from improper use and disclosure;
(2) An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law; and
(3) Adequate written assurances that the PHI will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research project, or for other research for which the use or disclosure of PHI would be permitted;
(4) The research could not practicably be conducted without the waiver or alteration; and
(5) The research could not practicably be conducted without access to and use of the PHI.

45 C.F.R. § 164.512(i).

25.4 Preparation for Research Projects

The HIPAA Privacy Rule allows use of PHI preparatory work relating to research without an authorization or institutional review board or privacy board waiver. The covered entity must obtain from the researcher representations that:

(1) Use or disclosure is sought solely to review protected health information as necessary to prepare a research protocol or for similar purposes preparatory to research;
(2) No protected health information is to be removed from the covered entity by the researcher in the course of the review; and
(3) The protected health information for which use or access is sought is necessary for the research purposes.

45 C.F.R. § 164.512(i)(1)(ii).
CHAPTER 26 - CASES REQUIRING REPORT TO LAW ENFORCEMENT OR HEALTH AUTHORITIES

26.1 Reports to Law Enforcement Authorities
Montana law requires certain cases to be reported to law enforcement authorities or to other persons who are in turn required to report to law enforcement authorities. In some cases, the law specifies whether the report must be written or made by telephone and the time within which the report must be made. Health care facility policy concerning required reports should contain a mechanism for insuring that physicians and employees responsible for filing reports are aware of applicable legal requirements. Where several categories of health care personnel (i.e., physicians and nurses) share legal responsibility for making the report, health care facility policy should delineate who has primary responsibility for making the report and provide a mechanism for verification that the report was made.

26.2 Cases Requiring a Report to Law Enforcement Authorities
The following situations require a report to law enforcement authorities:

**Stab and Gunshot Wounds.** A physician, nurse, or other licensed health care professional must report a stab or gunshot wound to law enforcement authorities by the fastest possible means. Within 24 hours, a written follow-up report, including the victim's name and address, must be sent by regular mail. [Mont. Code Ann. § 37-2-302.](#)

**Abused or Neglected Children.** The HIPAA Privacy Rule expressly authorizes the reporting under state law of abused or neglected children. [45 C.F.R. § 164.512(b)(1)(ii).](#) Health care personnel, among others, who know or have reasonable cause to suspect, as a result of information they receive in their professional or official capacity, that a child is abused or neglected they shall report the matter promptly to the Department of Public Health and Human Services. The department of family services is then required to notify the county attorney.

Montana statutes provide the following requirements regarding reporting child abuse and neglect:

(2) Professionals and officials required to report are:

(a) a physician, resident, intern, or member of a hospital's staff engaged in the admission, examination, care, or treatment of persons;

(b) a nurse, osteopath, chiropractor, podiatrist, medical examiner, coroner, dentist, optometrist, or any other health or mental health professional;

(c) religious healers;
(d) school teachers, other school officials, and employees who work during regular school hours;

(e) a social worker, operator or employee of any registered or licensed day-care or substitute care facility, staff of a resource and referral grant program organized under 52-2-711 or of a child and adult food care program, or an operator or employee of a child-care facility;

(f) a foster care, residential, or institutional worker;

(g) a peace officer or other law enforcement official;

(h) a member of the clergy, as defined in 15-6-201(2)(a);

(i) a guardian ad litem or a court-appointed advocate who is authorized to investigate a report of alleged abuse or neglect; or

(j) an employee of an entity that contracts with the department to provide direct services to children.

(3) A professional listed in subsection (2)(a) or (2)(b) involved in the delivery or care of an infant shall report to the department any infant known to the professional to be affected by a dangerous drug, as defined in 50-32-101.

(4) Any person may make a report under this section if the person knows or has reasonable cause to suspect that a child is abused or neglected.

(5)(a) Except as provided in subsection (5)(b) or (5)(c), a person listed in subsection (2) may not refuse to make a report as required in this section on the grounds of a physician-patient or similar privilege.

(b) A member of the clergy or a priest is not required to make a report under this section if:

(i) the knowledge or suspicion of the abuse or neglect came from a statement or confession made to the member of the clergy or the priest in that person's capacity as a member of the clergy or as a priest;

(ii) the statement was intended to be a part of a confidential communication between the member of the clergy or the priest and a member of the church or congregation; and

(iii) the person who made the statement or confession does not consent to the disclosure by the member of the clergy or the priest.
(c) A member of the clergy or a priest is not required to make a report under this section if the communication is required to be confidential by canon law, church doctrine, or established church practice.

Mont. Code Ann. § 41-3-201(2)-(5).

Reports of known or suspected child abuse or neglect must contain the following:

- the names and addresses of the child and the child’s parents or other persons responsible for the child’s care;
- to the extent known, the child’s age and the nature and extent of the child's injuries, including any evidence of previous injuries;
- any other information that the maker of the report believes might be helpful in establishing the cause of the injuries or showing the willful neglect and the identity of person or persons responsible for the injury or neglect; and
- the facts which led the person reporting to believe that the child has suffered injury or injuries or willful neglect.

Mont. Code Ann. § 41-3-201(6). Montana statute does not specify a number of hours within which the report must be made; it is required to be made “promptly.”

Abuse, Sexual Abuse, Neglect or Exploitation of Elders or Developmentally Disabled Persons. Health care personnel must report the matter if they know or have reasonable cause to suspect, as a result of acting in their professional capacities, that an older person or a developmentally disabled person has been subjected to abuse, sexual abuse, neglect, or exploitation. In general, the report must be made to the department of family services or its local affiliate and the county attorney. Mont. Code Ann. § 52-3-811(1)(a). If the person is a resident of a long-term care facility, the report must be made to the long-term care ombudsman appointed under the provisions of 42 U.S.C. 3027(a)(12) and to the Department of Public Health and Human Services for the State of Montana. Mont. Code Ann. § 52-3-811(1)(b). Categories of health care personnel required to report known or suspected cases of abuse, sexual abuse, neglect or exploitation of older persons or developmentally disabled persons are:

- physicians, residents, interns, professional or practical nurses, physician's assistants, and members of a hospital staff engaged in the admission, examination, care or treatment of persons;
- osteopaths, dentists, denturists, chiropractors, optometrists, podiatrists, medical examiners, coroners, ambulance attendants, and any other health or mental health professional.
- a social worker or caseworker.
- persons employed by nursing home or other adult care settings.
- attorneys, unless attorney-client privilege applies
- law enforcement officers
Mont. Code Ann. § 52-3-811(2). The report of abuse, etc., of an older person or developmentally disabled person may be made orally by telephone or in person, or in writing. Mont. Code Ann. § 52-3-812(1). While the applicable statutes do not specify the time within which the report must be made, it should be made promptly. The report must contain the following information:

- the names and addresses of the older person or the developmentally disabled person and the person, if any, responsible for the person's care;
- the name and address, if available, of the person who has abused, sexually abused, neglected or exploited the older person or the developmentally disabled person;
- to the extent known, the person's age and the nature and extent of the abuse, sexual abuse, neglect or exploitation, including any evidence of previous injuries sustained by the older person or developmentally disabled person; and
- the name and address of the person making the report.

Mont. Code Ann. § 52-3-812(2).

The HIPAA Privacy Rule authorizes reporting of disclosures required by law. 45 C.F.R. § 164.512(a). The Montana Elder and Persons with Developmental Disability Abuse Prevention Act, Montana Code Annotated, Title 52, chapter 3, part 8, requires the above-listed classes of persons to report suspected abuse. Other persons are permitted, but not required, to report suspected abuse. Mont. Code Ann. § 52-3-811(4). The HIPAA Privacy Rule authorizes such permissive reports, but only if certain safeguards are observed. 45 C.F.R. § 164.512(c).

26.3 Cases Requiring a Report to Health Authorities

Montana Code Annotated Section 37-2-301 provides that a physician or other practitioner of the healing arts must report suspected cases of communicable disease to the local health officer on a form prescribed by the Montana Department of Public Health and Human Services (“DPHHS”). The information reported must be limited to protected health information (“PHI”) expressly required by law. Failure to report suspected communicable disease is a misdemeanor. A copy of the prescribed DPHHS form is attached as MHA Form 26-1, Confidential Case Report.

The following types of cases require a report to health authorities such as the DPHHS and/or local health authorities.

(a) AIDS, as defined by the centers for disease control, or HIV infection, as determined by a positive result from a test approved by the federal food and drug administration for the detection of HIV, including but not limited to antibody, antigen, or HIV nucleic acid tests;

(b) Amebiasis;

(c) Anthrax;
(d) Botulism (including infant botulism);

(e) Brucellosis;

(f) Campylobacter enteritis;

(g) Chancroid;

(h) Chickenpox;

(i) Chlamydial genital infection;

(j) Cholera;

(k) Colorado tick fever;

(l) Cryptosporidiosis;

(m) Cytomegaloviral illness;

(n) Diarrheal disease outbreak;

(o) Diphtheria;

(p) Encephalitis;

(q) Escherichia coli 0157:H7 enteritis;

(r) Gastroenteritis outbreak;

(s) Giardiasis;

(t) Gonorrhea;

(u) Gonococcal ophthalmia neonatorum;

(v) Granuloma inguinale;

(w) Haemophilus influenzae B invasive disease (meningitis, epiglottitis, pneumonia, and septicemia);

(x) Hansen's disease (leprosy);

(y) Hantavirus pulmonary syndrome;
(z) Hemolytic uremic syndrome;

(aa) Hepatitis A, B (acute or chronic), or C (acute or chronic);

(ab) Kawasaki disease;

(ac) Influenza;

(ad) Lead poisoning (levels $ 10$ micrograms per deciliter);

(ae) Legionellosis;

(af) Listeriosis;

(ag) Lyme disease;

(ah) Lymphogranuloma venereum;

(ai) Malaria;

(aj) Measles (rubeola);

(ak) Meningitis, bacterial or viral;

(al) Mumps;

(am) Ornithosis (psittacosis);

(an) Pertussis (whooping cough);

(ao) Plague;

(ap) Poliomyelitis, paralytic or non-paralytic;

(aq) Q-fever;

(ar) Rabies or rabies exposure (human);

(as) Reye's syndrome;

(at) Rocky Mountain spotted fever;

(au) Rubella (including congenital);

(av) Salmonellosis;
(aw) Severe acute respiratory syndrome (SARS);
(ax) Shigellosis;
(ay) Smallpox;
(az) Streptococcus pneumoniae invasive disease, drug resistant;
(ba) Syphilis;
(bb) Tetanus;
(bc) Tickborne relapsing fever;
(bd) Transmissible spongiform encephalopathies;
(be) Trichinosis;
(bf) Tuberculosis;
(bg) Tularemia;
(bh) Typhoid fever;
(bi) Yellow fever;
(bj) Yersiniosis;
(bk) Illness occurring in a traveler from a foreign country;
(bl) An occurrence in a community or region of a case or cases of any communicable disease in the "Control of Communicable Diseases Manual, An Official Report of the American Public Health Association", (18th edition, 2004), 2000, with a frequency in excess of normal expectancy; and
(bm) Any unusual incident of unexplained illness or death in a human or animal.

A.R.M. 37.114.203.

26.4 Reporting Communicable Diseases
Health care personnel are required to report specified communicable diseases within the time and in the manner specified by the Administrative Rules of Montana. In summary, the reporting requirements are as follows:

26.4.1 Persons Who Must Report
The following persons must report communicable diseases if they know or have reason to believe a case exists – a physician, dentist, nurse, medical examiner, other health care practitioner, administrator of a health care facility, public or private school administrator, city health officer, or laboratorian. A.R.M. 37.114.201(1).

26.4.2 To Whom Report Must be Made
The report must be made to the local health officer, such as the county health department. A.R.M. 37.114.201(1).

26.4.3 When to Report – “Immediately”
Communicable disease cases must be reported to the local health officer immediately. A.R.M. 37.114.201(1). The local health officer will then make appropriate reports to the Department of Public Health and Human Services.

26.4.4 Required Information
The following information must be reported:

- name and age of the case;
- dates of onset of the disease or condition and the date the disease or condition was reported to the health officer;
- whether or not the case is suspected or confirmed;
- the name and address of the case’s physician; and
- the name of the reporter or other person the department [DPHHS] can contact for pertinent information about the case.

A.R.M. 37.114.205(1).

26.4.5 Administrative Rules
The Administrative Rules of Montana that govern reporting requirements for communicable diseases are also reproduced below.

37.114.201 REPORTERS

(1) With the exception noted in (3) below, any person, including but not limited to a physician, dentist, nurse, medical examiner, other health care practitioner, administrator of a health care facility, public or private school administrator, or laboratorian who knows or has reason to believe that a case exists shall immediately report to the local health officer the information specified in ARM 37.114.205(1) through (2).

(2) A local health officer must submit to the department, on the schedule noted in ARM 37.114.204, the information specified in ARM 37.114.205
concerning each confirmed or suspected case of which the officer is informed.

(3) A state funded anonymous testing site for HIV infection is not subject to the reporting requirement in (1) with regard to HIV testing.

37.114.205 REPORT CONTENTS

(1) A report of a case of reportable disease or a condition which is required by §37.114.204(1) or (2) must include, if available:

(a) name and age of the case;

(b) dates of onset of the disease or condition and the date the disease or condition was reported to the health officer;

(c) whether or not the case is suspected or confirmed;

(d) name and address of the case's physician; and

(e) name of the reporter or other person the department can contact for further information regarding the case.

(2) The information required by (1) must be supplemented by any other information in the possession of the reporter which the department requests and which is related to case management and/or investigation of the case.

(3) The laboratory reports required by §37.114.204(5) and the numerical report required by §37.114.204(3) need contain only the information specified in those sections.

(4) The name of any case with a reportable disease or condition and the name and address of the reporter of any such case are confidential and not open to public inspection.

37.8.1801 REPORTABLE TUMORS

(1) The following tumors are designated as reportable:

(a) malignant neoplasm, with the exception of a basal or squamous carcinoma of the skin;

(b) skin cancer of the labia, vulva, penis or scrotum;

(c) benign tumor of the brain, including a:
(i) meningioma (cerebral meninges);

(ii) pinealoma (pineal gland); or

(iii) adenoma (pituitary gland);

(d) carcinoid tumor, whether malignant, benign or not otherwise specified (NOS).

(2) A benign tumor other than one of those listed in (1) may be reported to the department for inclusion in the tumor registry if prior approval has been obtained from the Department of Public Health and Human Services, Public Health and Safety Division, Montana Central Tumor Registry, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) A tumor which is otherwise reportable, but has been diagnosed and recorded using the words "apparently", "appears", "comparable with", "compatible with", "consistent with", "favors", "malignant appearing", "most likely", "presumed", "probable", "suspected", "suspicious", or "typical of" with reference to that tumor is considered reportable.

(4) In order for the department to maintain current reporting, hospitals and physicians shall submit to the department information on reportable tumors within six months from the first inpatient or outpatient date that the patient was seen with cancer; independent laboratories shall submit to the department information on reportable tumors within six months from the date the laboratory service associated with the tumor was rendered.

37.8.1802 REQUIRED RECORDS, INITIAL ADMISSION AND TREATMENT

(1) Whenever a hospital initially provides medical services to any patient relating to a tumor designated as reportable by ARM 37.8.1801, it must collect, record, and make available to the department the following information about that patient:

(a) name and current physical address of patient;

(b) patient's physical address at time of diagnosis;

(c) social security number;

(d) name of spouse, if any;

(e) phone number;
(f) race, Hispanic origin if applicable, sex, and marital status;

(g) age at diagnosis, place of birth, and month, day, and year of birth;

(h) name, address, and phone number of friend or relative to act as contact, plus relationship of that contact to patient;

(i) date and place of initial diagnosis;

(j) primary site of tumor (paired organ);

(k) sequence of primary tumors if more than one;

(l) other primary tumors;

(m) method of confirming diagnosis;

(n) histology, including dates, place, histologic type and slide number;

(o) summary staging, including whether in situ, localized, regional, distant or unstaged, with no information, or whether AJCC or TNM staging is utilized, and, if so, the findings of this staging;

(p) description of tumor and its spread, if any, including size in centimeters, number of positive nodes, number of nodes examined and site of distant metastases;

(q) procedures done to diagnose or stage tumors including dates, procedures, and results (such as physical exams, scopes, x-rays, scans, or lab tests);

(r) cumulative summary of all therapy directed at the subject tumor, including:

   (i) date of therapy;

   (ii) specific type of surgery or radiation therapy, if any, and details of chemical, hormonal, or other kinds of treatment; and

   (iii) if no therapy given, reason for lack of therapy.
(s) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence, or recurring, or status unknown;

(t) if recurrence of tumor, date, type, and distant sites of first recurrence;

(u) names of physicians primarily and secondarily responsible for follow up;

(v) date of each follow up;

(w) if patient has died, date of death, place, cause, and whether autopsy performed;

(x) primary payer at diagnosis;

(y) usual occupation and industry; and

(z) tobacco and alcohol use history.

37.8.1803 REQUIRED RECORDS, FOLLOW UP

(1) Whenever a patient for whom information has been provided to the tumor registry is admitted to the hospital providing the information on an inpatient or outpatient basis for further treatment related to the tumor for which original registration in the tumor registry was made, the hospital must keep on file the following information:

(a) patient's name, noting any change from previous records;

(b) any paired organ involvement, noting sequence;

(c) subsequent histology, including dates, place, histology type, slide number and procedure;

(d) date, type of procedure and findings of any surgery or other exploratory measure;

(e) date and type of any administration of radiation;

(f) date of any administration of hormones, chemotherapy, immunotherapy or any other kind of treatment;
(g) date of death and/or last follow up;

(h) if death has occurred, the place, cause and whether an autopsy was performed;

(i) if an autopsy was performed, its findings pertaining to cancer;

(j) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence, or has recurred, or status is unknown;

(k) if recurrence of tumor, date, type, and distant sites of first recurrence; and

(l) names of those physicians primarily and secondarily responsible for follow up treatment.

26.5 EMTs Report of Exposure to Infectious Disease by Emergency Services Provider

Health care facilities are required to designate an Infectious Disease Control Officer and an Alternate on a form developed by DPHHS. If an Emergency Services Provider is exposed to an infectious disease, under Montana Code Annotated Sections 50-16-701 through 50-16-711, the Infectious Disease Control Officer will receive a “Report of Exposure Form” which triggers certain responsibilities for the health care facility.
CHAPTER 27 - RETENTION OF MEDICAL RECORDS

27.1 How Long to Retain
State and federal law contains various requirements for the retention of medical records. In general, hospital records must be kept for a longer period of time than medical records at other health care facilities.

27.2 Civil Actions
The federal statute of limitations for civil penalties is six (6) years – this is why the records retention period for activities that may incur federal penalties is often six years. 42 C.F.R. § 1003.132.

27.3 Federal Records Retention Requirements

- Medicare – Because of the federal statute of limitations, medical and billing records are maintained for six (6) years.
- HIPAA Providers – A record of disclosures, authorization forms, business associate agreements, notices of privacy practices, and an individual’s statement of disagreement with a medical record and the provider’s response, must be maintained for six (6) years. 45 C.F.R. § 164.528.
- Medicaid – Records must be retained for six years and three months from the date on which the service was rendered or until any dispute or litigation concerning the services is resolved, whichever is later. A.R.M. 37.85.414(1)(c).

27.4 Retention of Records – Montana Law

Montana Health Care Facilities (excluding hospitals). Medical records must be retained for five (5) years following the date of discharge or death. However, facilities that participate in the Medicaid and/or Medicaid programs will probably opt to keep all medical records for those programs’ minimum retention periods. A.R.M. 37.106.314.

Montana Hospitals. The individual’s entire medical record must be retained for at least ten years following the patient’s discharge or death. After the retention period, a hospital must keep a “core record” with certain defined elements for at least an additional ten years. A.R.M. 37.106.402.

Minors – Montana Hospitals. Medical records must be retained for at least ten (10) years after the date the minor attains the age of majority (18) or dies, whichever occurs first. A.R.M. 37.106.402(1).

Minors – Health Care Facilities other than Hospitals. Although Montana law does not contain a similar provision, the federal rules provide that medical records must be retained for at least three years after the minor reaches the age of majority. 42 C.F.R. § 483.75.
27.5 **Required Content of Retained Records in General**

“Medical record” means a written document which is complete, current, and contains sufficient information for planning a patient or resident’s care, reviewing and evaluating care rendered, evaluating a patient or resident’s condition, and for providing a means of communication among all persons providing care.  \textit{A.R.M. 37.106.301(11)}. 

27.6 **Provider’s Signature**

A signature of a physician may not be stamped on a medical record unless there is a statement in the facility administrator’s or manager’s file signed by the physician stating that the physician is responsible for the content of any document signed with his rubber stamp. \textit{A.R.M. 37.106.314(4)}. 

27.7 **Outpatient Facilities**

Medical records associated with outpatient facilities must include:

- Identification data;
- Chief complaint;
- Present illness;
- Medical history;
- Physical examination;
- Laboratory and x-ray reports;
- Treatment administered;
- Tissue report;
- Progress reports; and
- Discharge summary.

\textit{A.R.M. 37.106.1001(3)}

27.8 **Obstetrical and Newborn Medical Records**

Special requirements exist for obstetrical and newborn medical records. \textit{A.R.M. 37.106.402(2), (3)}. 

27.9 **Alternatives to Retaining Paper Medical Records**

A medical record may be microfilmed or preserved via any other electronic medium that yields a true copy of the record if the health care facility has the equipment to reproduce records on the premises. \textit{A.R.M. 37.106.314(3)}. There has been a growing national trend toward implementing electronic medical records for all patients. Future versions of this Consent Manual will reflect this trend.

27.10 **Retention Period of X-Rays, etc**

In hospitals, diagnostic imaging film and electrodiagnostic tracings must be retained for a period of five years; their interpretations must be retained for the same periods required for the medical record. \textit{A.R.M. 37.106.402(6)}. 

27.11 **Retention When Provider No Longer in Business**
A provider that is no longer in business is required to make arrangements for its medical records to be retained for the applicable legally required period of time. The records must be made available through another provider or by other means if another provider is not available.
APPENDIX A – FORMS

APPENDIX A

FORMS
MHA Form 3-1 - Admission Consent Form
[Health Care Facility]

Physician__________________________

Date of Admission: __ am / pm

I. Consent to Medical Treatment

A. I, (or_____________________________ [name of guardian or other authorized representative] authorized to act on behalf of [name of patient]) require inpatient care and hereby consent to such care, including routine medical procedures, and including those diagnostic and laboratory procedures my physician named above or other members of [name of facility medical staff] consider necessary.

B. I understand the practice of medicine is not an exact science and that no guarantees have been made to me regarding the result of any treatment I may receive at [name of facility].

C. I understand that, unless an emergency or other extraordinary unforeseen circumstances arise, this form constitutes consent to treatment that is routine in nature. No major procedure such as surgery will ordinarily be performed until such procedure has been explained to me by a health care professional and I have given my consent to such procedure.

D. I understand that my attending physician, as well as many other physicians at [name of facility] are not employees or agents of [name of facility], but merely have the right to use [name of facility]’s facilities for the treatment of patients. [If applicable, consider adding that radiologists, pathologists, anesthesiologists, etc. also are not employees or agents of the facility.] I also understand that for emergency or unscheduled services, [name of facility] may aid in my selection of physicians by an established “on call” procedure. I agree that [name of facility] is not responsible for the independent judgment of any of the physicians identified above.

E. [Name of facility] provides only general duty nursing care. Under this system, nurses are called to the bedside of a patient by a signal system. If the patient is in such condition to need continuous or special duty nursing care, such care must be provided by the patient or the patient's legal representative. [name of facility] is not required to provide continuous or special duty nursing care, and is hereby released from any liability arising from the failure to provide continuous or special duty nursing care.

F. I authorize [name of facility] to use its discretion to retain or dispose of any tissue removed during any treatment or diagnostic procedure.

II. Financial and Miscellaneous
A. Agreement of Financial Responsibility. I agree, whether signing as a patient or as the authorized representative of a patient, that, in consideration of the services [name of facility] will provide to the patient, I am individually obligated to pay in full the facility’s account for the patient when required by the facility. If the services of an attorney are required for collection of the patient's account, I agree to pay all reasonable attorney's fees and related collection expenses. I understand that delinquent accounts bear interest at the rate of __% per [month or year].

B. Assignment of Insurance Benefits. In the event the patient named in this document is entitled to insurance benefits of any kind arising out of any policy of insurance insuring the patient or any party liable to the patient, I assign such benefits to [name of facility] for application to the patient's bill. I am responsible for paying any part of the patient's bill not paid by insurance benefits or other third party payers.

C. Release of Information. Pursuant to the applicable law and in accordance with [name of facility]'s Notice of Privacy Practices, [name of facility] may provide any part of the patient's medical record to any person or entity that may be liable for all or part of the facility's charges for the patient, including, but not limited to, facility or medical service companies, insurance companies, workers' compensation carriers, or public assistance funds. The following insurance company(ies) or other third party payor(s) is/are expressly authorized to receive any part of the patient's medical record that is applicable to payment requested:

D. Personal Valuables. [Name of facility] asks that personal valuables be left at home when practical. Personal valuables include money, jewelry, glasses, dentures, documents and credit cards, plus any other items of an unusual or valuable nature. If not left at home, [name of facility] advises that, at the time of admission, personal valuables be deposited with facility personnel for safekeeping in the facility's safe. I will receive a receipt for any property deposited in the facility's safe. If I do not deposit personal valuables in the facility's safe, I understand that [name of facility] shall not be liable for loss or damage to any such property. I certify that I have read and understood this form, and that it has been fully explained to me if I have so requested. I certify that I am the patient, or the patient's authorized representative, and I am authorized to sign this document and accept its terms. I understand I am entitled to a copy of this document.

Date: ________________________

Patient

Witness

If the patient is unable to legally consent because he or she is a minor or is incapacitated, complete the following: (Check if applicable)
__ Patient is a minor
__ Patient is unable to consent because ____________________________________________.
__ Years of age

__________________________________________
Signature of Parent or Guardian

__________________________________________
Witness
MHA Form 3-2 - Consent to Operation and Other Medical Procedures

Date of Admission: _________ am/pm

Patient ____________________________________________________

1. I authorize and direct, _________________ my surgeon and /or associates or assistants of his or her choice to perform the following operation upon me:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

The nature of the operation has been explained to me and no warranty or guarantee has been made as to the result or cure. Specific risks which may be associated with such operation and which have been explained to me are:

__________________________________________________________________________

2. I hereby authorize and direct the above named surgeon and/or his or her associates or assistants to provide such additional services for me as my surgeon may deem reasonable and necessary, including, but not limited to, the administration and maintenance of the anesthesia, and the performance of services involving pathology and radiology, and I hereby consent thereto.

3. I understand that the above-named surgeon and the associates or assistants chosen by him/her to assist in performing such operation are not the agents, servants or employees of the above-named hospital, nor of any surgeon, but are independent contractors engaged by me. [Note: this provision should be omitted with respect to health care personnel, including physicians, who are hospital employees.]

4. I hereby authorize the hospital pathologist to use his discretion in the disposal of any severed tissue or member except:

5. I further consent to the administration of such drugs, infusions, plasma or blood transfusions or any other treatment, injection or procedure deemed necessary in the judgment of my surgeon.

6. It has been explained to me that, during the course of the operation, unforeseen conditions may be revealed or encountered which necessitate surgical or other procedures in addition to or different from those contemplated. I therefore request and authorize my surgeon and/or my surgeon's associates to perform such additional procedures as my surgeon deems necessary or desirable.

I certify that I have read and understood this form, and that it has been fully explained to me if I have so requested. I certify that I am the patient, or the patient's authorized representative, and I
am authorized to sign this document and accept its terms. I understand I am entitled to a copy of this document.

Date: ________________________________

Patient ________________________________

Witness ________________________________

If the patient is unable to legally consent because he or she is a minor or is incapacitated, complete the following: (Check if applicable)

___ Patient is a minor

___ Patient is unable to consent because: ____________________________________________

___ Years of age

__________________________________________
Signature of Parent or Guardian

__________________________________________
Witness
MHA Form 3-3 - Consent to Procedure

Patient ________________________________

Physician ______________________________

Treatment/Procedure ________________________________

IMPORTANT!
Read Before Signing

___ My physician thoroughly explained to me the nature of my ailment and the treatment/procedure in a manner I understand. My physician answered all my questions to my satisfaction.

___ My physician explained to me that ANY surgery or treatment is inherently risky and offered no guarantees of improvement or cure.

___ My physician told me that SOME of the remote but severe risks might be death, paralysis, infection, permanent brain damage, etc.

___ My physician also told me of other substantial and special risks that can happen with this treatment/procedure, including anesthesia.

___ My physician told me that, although unlikely, some of these risks or complications could still happen to me and that I should recognize this possibility.

___ My physician told me the alternatives and options to the treatment/procedure, including no treatment at all.

Comments: _______________________________________

I certify that I have read and understood this form, and that it has been fully explained to me if I have so requested. I certify that I am the patient, or the patient's authorized representative, and I am authorized to sign this document and accept its terms. I understand I am entitled to a copy of this document.

Date: ______________________________

Patient ________________________________

Witness ________________________________
If the patient is unable to legally consent because he or she is a minor or is incapacitated, complete the following: (Check if applicable)

___ Patient is a minor

___ Patient is unable to consent because: ____________________________________________.

___ Years of age

________________________________________
Signature of Parent or Guardian

________________________________________
Witness

It is your legal right to determine the extent of your medical/surgical care. If you have any further questions, ask your physician before signing this form.
MHA Form 3-4 - Consent to Anesthesia

Your physician has requested that we provide anesthesia services for you during the operation or diagnostic procedure that you are considering. We are a group of anesthesiologists and nurse anesthetists who work together as teams.

All types of anesthesia involve some risk. Complications from all forms of anesthesia are rare, but may occur. There is a very remote possibility of death as a complication of any type of anesthesia.

The type of anesthesia services that you receive is determined by many factors including your physical condition, the nature of the procedure, the preference of your physician and your preference. The type that has been recommended for you and the available alternative procedures, if any, are identified below:

_________________________________________________________

_________________________________________________________

_________________________________________________________

Special Considerations, if any: __________________________________

_________________________________________________________

_________________________________________________________

_________________________________________________________

I certify that I have read or had read to me the contents of this form. I understand the risks and alternatives involved in this procedure. I have had the opportunity to ask any questions and I am authorized to sign this document and accept its terms. I understand I am entitled to a copy of this document.

Date: ___________ Time: ______________

_________________________________________________________

Patient or person legally authorized to consent for patient

_________________________________________________________

Relationship if other than patient

_________________________________________________________

Witness

_________________________________________________________

Anesthesiologist/Nurse Anesthetist
MHA Form 4-1 - Consent to Outpatient Treatment

[name of health care facility]

Patient ____________________________________________

Physician __________________________________________

Date: ____________________

Consent to Medical Treatment

A. My physician has referred me to [name of health care facility] on an outpatient basis for treatment and/or diagnosis.

B. I authorize (specify personnel performing) to perform the following procedure(s):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

C. Likely consequences of the proposed procedure(s) are:

________________________________________________________________________

________________________________________________________________________

D. Risks associated with the procedure(s) set forth above that have been explained to me are: Feasible alternative(s) to the proposed procedure(s) is/are:

________________________________________________________________________

________________________________________________________________________

E. Feasible alternative(s) to the proposed procedure(s) is/are:

________________________________________________________________________

________________________________________________________________________

F. Comments on limitations to consents, if any:

________________________________________________________________________

________________________________________________________________________

G. I, (name of patient) ____________________________________________
(or I ____________________________________________
(name of parent or guardian or other authorized representative)) consent to and authorize the health care professionals named above, along with such assistants and associates as such health care professionals consider advisable, to perform the procedure(s) listed above.

H. I understand the practice of medicine is not an exact science and that no guarantees have been made to me with regard to the medical procedures set forth above.
I. Agreement of Financial Responsibility,

I agree, whether signing as a patient or as the authorized representative of a patient, that in consideration of the services [name of health care facility] will provide to the patient, I am individually obligated to pay in full the health care facility account of the patient when required by the health care facility. If the services of an attorney are required for collection of the patient's account, I agree to pay all reasonable attorney's fees and related collection expenses. I understand that delinquent accounts bear interest at the rate of - % per (month or year).

J. Assignment of Insurance Benefits.

In the event the patient named in this document is entitled to insurance benefits of any kind arising out of any policy of insurance insuring the patient or any party liable to the patient, I assign such benefits to [name of health care facility] for application to the patient's bill. I am responsible for paying any part of the patient's bill not paid by insurance benefits or other third party payers.

K. Release of Information.

[Name of health care facility] may release my health care information only to the extent set forth in [name of facility]'s Notice of Privacy Practices and in accordance with applicable law. The following insurance company(ies) or other third party payor(s) is/are expressly authorized to receive any part of the patient's medical record that is applicable to payment requested:

I certify that I have read and understood this form, and that it has been fully explained to me if I have so requested. I certify that I am the patient, or the patient’s authorized representative, and I am authorized to sign this document and accept its terms. I understand I am entitled to a copy of this document.

Date: _______________________

____________________________________
Patient

____________________________________
Witness
If the patient is unable to legally consent because he or she is a minor or is incapacitated, complete the following: (Check if applicable)

____ Patient is a minor
____ Patient is unable to consent because ________________________________

________________________________________________________
Signature of Parent or Guardian

________________________________________________________
Witness
MHA Form 5-1 - Refusal to Consent to Treatment
[name of facility]

Patient ____________________________________________

Physician __________________________________________

Date _____________ _____ am / pm

1. The above-named physician ("my physician") has explained to me that I suffer from the following condition: ____________________________________________________________

2. My physician has explained to me the serious need for the following treatment(s): _________ ____________________________________________________________

3. My physician has explained to me that the likely consequences of refusing the recommended treatment are: ____________________________________________________________

4. I understand that refusal of the treatment recommended by my physician may endanger my life or health. Knowing this, I refuse consent to such treatment. My reason for refusing such treatment is: ____________________________________________________________

I hereby release my physician, [name of health care facility] and the health care personnel attending me from any liability or responsibility for not providing the treatment described above.

________________________________________
Patient Signature

________________________________________
Witness

________________________________________
Witness
MHA Form 5-2 - Release by Closest Relative Refusal of Treatment

NOTE: No legal requirement exists that a spouse or other closest relative concur in the refusal of treatment by a competent patient. However, a signed release from such relative may forestall future problems in the event the relative has second thoughts about the refusal of treatment.

[name of facility]

Patient ________________________________

Physician ________________________________

Date: ________ _______ am / pm

1. My __________________________ (spouse, parent, etc.) has refused consent to the following treatment(s): __________________________________________________________
   __________________________________________________________
   __________________________________________________________

2. The reason for such refusal is: __________________________________________________________
   __________________________________________________________
   __________________________________________________________

3. I understand the above-named physician has explained to my (spouse, parent, etc.) the serious need for the treatment described above, and the probable consequences if the treatment is refused. I understand the above-described physician believes refusal of the treatment may seriously endanger my _________________ (spouses, parents, etc.) life or health. Nonetheless, I wish such refusal to be honored, and I release the above-named physician, [name of health care facility] and the health care personnel caring for my (spouse, parent, etc.) from any liability or responsibility for not providing the treatment described above.

I certify that I am 18 years of age or older, of sound mind, and I am the patient's closest living relative available for consultation concerning the patient's care.

________________________________________________________________________

Name

________________________________________________________________________

Witness

________________________________________________________________________

Witness
MHA Form 5-3 - Refusal to Permit Transfusion

[name of facility]

Patient _________________________________

Physician _______________________________

Date: _________________ _______ am / pm

1. The above-named physician has advised me that the transfusion of blood, plasma or other blood product may be necessary to preserve my life or health. My physician has explained to me that the likelihood I will require a transfusion is as follows: ______________________
   ___________________________________________________________________
   ___________________________________________________________________

2. I understand if a transfusion is indicated, my refusal of such transfusion may endanger my life or health. I understand there is no effective alternative to a transfusion.

3. Knowing the risks involved, I nonetheless refuse to permit a transfusion. My reason for such refusal is: _________________________________
   ___________________________________________________________________
   ___________________________________________________________________

I hereby release my physician, [name of facility] and the health care personnel attending me from any liability or responsibility for not providing a transfusion.

_______________________________
Patient Signature

_______________________________
Witness

_______________________________
Witness
MHA Form 5-4 - Refusal to Permit Transfusion (Jehovah’s Witnesses)
[name of facility]

Patient ____________________________
Physician ____________________________
Date: _______ _____ am / pm

I am a member of the religious denomination commonly known as the Jehovah’s Witnesses and scrupulously follow the tenets and beliefs of that faith. It is my express understanding and belief that my faith does not allow the administration of blood transfusions for any purpose whatsoever. Therefore, I expressly refuse to allow anyone to administer a blood transfusion to me during the course of the major surgery scheduled for me at [name of health care facility]. The risks attendant to my refusal to permit such a transfusion have been fully explained to me and I fully understand such risks. In addition, I fully understand that I will in all probability need a transfusion of blood and that if such a transfusion is not allowed by me, my chances for regaining normal health are seriously reduced, and I also understand that in all probability my refusal to allow such treatment or procedures will seriously imperil my life and may possibly result in my death. Even with this full understanding, I still refuse to give permission for such a transfusion of blood or blood derivatives as required for my safety or life, and I hereby release the above-named physician, [name of health care facility], and the health care personnel attending me or who will be involved in the scheduled surgery, from all liability for damages or injury to me or the death of me for respecting and following my express wishes and directions on this matter. This release includes a full release from all manner of causes of action or suits which I now have or will have against the above-named physician, [name of health care facility] and the health care personnel attending me or who will be involved in the scheduled surgery, by reason of the performance of the scheduled surgery.

I realize that [name of health care facility] is not obligated to allow any surgical procedure to be performed on me. It is in consideration for [name of health care facility]’s permission to allow a surgical procedure to be performed upon me under these special circumstances and other considerations that I expressly release such health care facility and the physicians and health care personnel involved.

Although I refuse transfusion of whole blood, I agree to treatment with the following blood products, if deemed necessary: ____________________________

I have read this release and understand fully its contents and voluntarily execute it fully realizing what I am doing by signing it.

________________________________________
Patient Signature

________________________________________
Witness
MHA Form 6-1 - Acknowledgement of Release From
Health Care Facility Against Medical Advice
[Name of facility]

This is to certify that ___________________________ (Patient) has decided to leave [name of facility] (the Hospital) against medical advice of the attending physician and hospital administration. Patient or authorized representative hereby certifies he/she is the legally authorized person to consent to the release of the Patient. Patient or his/her authorized representative is competent and understands the risks of leaving, including permanent disability and/or death, and has had an opportunity to ask questions about his/her condition. Patient has been informed that he/she may return for care at any time. Patient or authorized representative is causing the Patient to be released against medical advice for the following reason(s):

________________________________________________________________________

________________________________________________________________________

Patient or his/her authorized representative further hereby releases the attending physician, the Hospital and its agents and employees from all responsibility for any adverse effects which may result from Patient or his/her authorized representative’s decision to leave the Hospital against medical advice.

Patient or his/her authorized representative acknowledges the Patient’s attending physician, __________________________, has advised Patient or his/her authorized representative it is against medical advice for Patient to leave the Hospital at this time and in this condition. Specifically, Patient or his/her authorized representative has been advised by his/her attending physician of the following risks of leaving the Hospital at this time and the reasons for the attending physician’s medical opinion:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Patient or Authorized Representative’s Signature __________________________ Date ____________

Printed Name of Patient or Authorized Representative __________________________

Relationship to Patient (if applicable) __________________________

Witness (Signature and Printed Name) __________________________

Witness (Signature and Printed Name) __________________________
I, __________________________, (Attending Physician) hereby certify that I have advised the Patient named above that it is against medical advice for the Patient to leave the Hospital at this time and in this condition. Having heard and understood such advice and having had the opportunity to ask any questions regarding Patient’s condition and treatment, Patient has elected to leave the Hospital against medical advice.

_________________________________________
Attending Physician’s Signature

_________________________________________
Printed Name of Attending Physician

_________________________________________
Date
MHA Form 6-2 - Release of Side Rails

Patient

Physician

Date: _______________   _____am / pm

Having been informed by [name of facility] that protective side rails should be placed on my bed and raised for my personal protection, I hereby instruct [name of facility] and its employees not to place or raise protective side rails on my bed and hereby assume all risk in connection therewith and fully release the said hospital, its employees and my physician from any and all liability for any injury or damage to me by reason of the lack of protective side rails on my bed. My physician has explained to me the alternatives and known risks associated with the release of side rails.

________________________________________________________
Alternatives are:

________________________________________________________

Known risks are:

________________________________________________________

If applicable, I have the following preexisting condition that may place me at risk of injury if side rails are used:

________________________________________________________

Patient Signature

________________________________________________________

Authorized Representative of Patient, if applicable

________________________________________________________

Relationship

________________________________________________________

Witness

________________________________________________________

Witness
MHA Form 7-1 - Consent to Amniocentesis
[Name of facility]

Patient ________________________________

Physician ______________________________

Date: ________ _____ am / pm

1. The above-named physician ["my physician"] has informed me of the availability of amniocentesis. Amniocentesis can be used to detect the presence of many genetic abnormalities, including Down’s Syndrome, Tay-Sachs disease, sickle cell disorder, and neural tube defects. The sex of the fetus can also be determined. In addition to the above, my physician has discussed with me the following genetic abnormalities that may be detected by amniocentesis:

_________________________________________________________________

_________________________________________________________________

2. My physician has explained to me that it is recommended that pregnant women in certain risk groups be informed of the opportunity to undergo amniocentesis. Amniocentesis is advised for me because of the following risk factor(s):

_________________________________________________________________

_________________________________________________________________

3. My physician has explained to me that amniocentesis involves extracting a sample of amniotic fluid, and that the test involves some risks to the woman and the fetus. Risks, although rare, that may result from this procedure are:

_________________________________________________________________

_________________________________________________________________

4. I understand that the practice of medicine is an inexact science and that a particular amniocentesis may not in every instance detect genetic abnormalities, whether or not such abnormalities are commonly detectable by amniocentesis. In other words, there is no guaranty that amniocentesis will detect an abnormal fetus.

5. I do ___ / do not ____ wish to be informed of the sex of the child.

Patient Signature

Witness
MHA Form 7-2
Parental Acknowledgment
Refusal of Newborn Metabolic and Genetic Testing
[insert name of facility]

Patient ________________________________

Physician ________________________________

I, ________________________________________, am the parent or legal guardian
(Print name of Parent or Legal Guardian)
of ________________________________________, born on _________________, 20__.
(Print name of Newborn)

By signing below, I acknowledge and agree that:

I understand that Montana law requires all birth facilities, including [insert name of birth
facility], to perform metabolic and genetic screening on all newborn children. I have received
education and information from [insert name of birth facility] about how important newborn
metabolic and genetic screening is to make sure that my newborn is not afflicted with a
metabolic and genetic condition. Even though I have been given this education, I have decided
NOT to have my newborn screened for metabolic and genetic conditions by [insert name of birth
facility].

I understand that my decision NOT to have my newborn screened for metabolic and genetic
conditions may impair the ability of health care providers to treat such conditions or symptoms
related to such conditions.

I accept full responsibility for the outcomes of refusing to have my newborn screened for
metabolic and genetic conditions. I agree that [insert name of birth facility] and anyone
employed by them is not responsible for any consequences to my newborn arising from my
decision NOT to have my baby screened for metabolic and genetic conditions. I understand that
a signed copy of this form may be provided to appropriate state agencies as required by Montana
laws and regulations.

Signed __________________________________________________________

Address __________________________________________________________

______________________________________________________________

Date: ______________________  Time: ___________

Witness: _________________________________________________________
MHA Form 7-3 - Consent to Newborn Hearing Screening
[name of facility]

Patient ________________________________

Physician ______________________________

Date: ________ _____ am / pm

I, agree to hearing screening tests for my newborn child. I have received educational materials about newborn hearing screening. My physician or nurse has explained any questions I may have about the newborn hearing screening test(s).

____________________________________  ________________
Signature of Parent/Guardian             Date
MHA Form 7-4
Parental Acknowledgment
Refusal of Newborn Hearing Screening
[insert name of facility]

Patient ____________________________________________

Physician __________________________________________

I, ________________________________________________, am the parent or legal guardian

(Print name of Parent or Legal Guardian)

of ______________________________________________, born on ___________________, 20___.

(Print name of Newborn)

By signing below, I acknowledge and agree that:

I have received education and information from [insert name of birth facility] about how important newborn hearing screening is to make sure that my newborn is not deaf or hard of hearing. Even though I have been given this education, I have decided NOT to have my newborn screened for any hearing deficit by [insert name of birth facility].

I understand that hearing experts for babies recommend hearing testing for all newborns within the first month of life so that early intervention will make it more likely that my baby will be able to have normal language development if there is a hearing loss. I understand that my decision NOT to have my newborn screened for hearing loss may mean my child’s development of language and learning skills may be damaged if my baby does have a hearing loss.

I accept full responsibility for the outcomes of refusing to have my newborn screened for hearing loss. I agree that [insert name of birth facility] and anyone employed by them is not responsible for any consequences to my newborn arising from my decision NOT to have my baby screened for hearing deficits. I understand that a signed copy of this form will be provided to appropriate state agencies as required by Montana laws and regulations.

Signed __________________________________________________________

Address_________________________________________________________

________________________________________________________

Date: ______________________  Time: ______________

Witness: ________________________________________________
MHA Form 7-5 - Consent to Maternity Care
[name of facility]

Patient ________________________________

Physician ______________________________

Date: ________ _____ am / pm

I consent to have the above-named physician, and such other physicians or persons as are needed to assist him or her, deliver my baby. The above-named physician has explained to me the nature of the childbirth method we intend to use and how the delivery is expected to be conducted. However, I understand that circumstances at the time of delivery may require another method to be used. I therefore permit the physician to use whatever method of delivery he or she feels is best for me and my baby under the circumstances arising.

The above-named physician has also explained that the following risks are associated with childbirth in general and the method of delivery we have selected in particular: (to be filled in by the doctor)

________________________________________________________________________

________________________________________________________________________

I also consent that my doctor, other physicians that he or she may appoint, [name of health care facility] and its employees, and all other persons participating in our care may give my baby and me whatever additional care and treatment are necessary for our well being before, during and after the delivery, including transfusion of blood and blood plasma.

No assurances have been given concerning the results of the delivery or any other care that my baby or I may receive while in the health care facility.

________________________________________________________________________

Patient's Signature

________________________________________________________________________

Witness

Date: ________ _____ am / pm

The patient is unable to consent because:

________________________________________________________________________

________________________________________________________________________

I therefore consent for the patient.
Signature
(husband, parent of minor or legal guardian)

Witness

Date: ________   _____ am / pm
I declare that I have personally explained the above information to the patient or the patient's representative.

Attending Physician's Signature

Witness

Date: ________   _____ am / pm
MHA Form 7-6 - Consent to Circumcision of Expected Child
[name of facility]

Patient ____________________________________________

Physician __________________________________________

Date: ________ _____ am / pm

I, the undersigned, do hereby agree and consent to have the above-named physician circumcise my expected child, if male, and to perform any other therapeutic procedure and to transfuse blood and/or blood plasma that the physician’s judgment may dictate to be advisable for my child’s well-being. No warranty has been made as to the result of the operation. To the best of my knowledge, blood disorders (are) (are not) known in my family.

I understand that the above named physician and/or his or her assistants will be solely in control of such-operation, [add if applicable: and the persons in attendance at such operation for the purpose of administering anesthesia or performing other professional services are not the agents, servants or employees of the above named hospital nor of any surgeon, but are independent contractors contracted by the undersigned.]

The undersigned has read the foregoing consent and has received a copy thereof.

Dated this ____ day __________________ of 200__

Mother of Expected Child ____________________________________________

Father of Expected Child ____________________________________________

________________________________

Witness
MHA Form 8-1 - Authorization to Treat Minor

(I)(We), the undersigned, parent(s) of _________________________, a minor, do hereby authorize ________________________________ as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any qualified physician, physician’s assistant or advanced practice registered nurse who is licensed to practice in the state of Montana, whether such diagnosis or treatment is rendered at the office of said physician or at any hospital.

Comments: [reason for parents' unavailability to consent, limitations on treatment consented to, etc., may be set forth]

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such medical or surgical diagnosis or treatment or hospital care which the aforementioned health care professional in the exercise of his or her best judgment may deem advisable.

This authorization shall remain effective until ___________, 20__, unless sooner revoked in writing delivered to said agent(s).

Date: __________________________

________________________________________
Father

________________________________________
Mother
STATE OF ______________________

County of ______________________

On the ______ day of ____________, 20__, before me, a Notary Public for the State of __________________, personally appeared _____________________________, known to me to be the person whose name is subscribed to the within instrument and acknowledged to me that ____________________________ he/she executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal the day and year in this certificate first above written.

NOTARY PUBLIC for the State of __________________
(SEAL)
Residing at ________________________________
My Commission expires ________________________

STATE OF ______________________

County of ______________________

On the ______ day of ____________, 20__, before me, a Notary Public for the State of __________________, personally appeared _____________________________, known to me to be the person whose name is subscribed to the within instrument and acknowledged to me that ____________________________ he/she executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal the day and year in this certificate first above written.

NOTARY PUBLIC for the State of __________________
(SEAL)
Residing at ________________________________
My Commission expires ________________________
MHA Form 8-2 - Consent to Medical Services by Minor
Authorized to Consent to Medical Treatment

NOTE: This form, if used, should be employed in addition to any other consent or admission-related forms.

For the purposes of obtaining diagnosis or treatment at [health care facility] or by any physician, physician’s assistant, advanced practice registered nurse, psychiatrist, psychologist or dentist associated with it, the undersigned certifies the following facts are true:

(Check as appropriate)

_____ 1. I am or have been married, or have had a child, or have graduated from high school.

_____ 2. I am living separate and apart from my parents or legal guardian and I am supporting myself.

Place of residence Phone

Place of residence of parents or guardian Phone

-AND-

I am managing my own financial affairs regardless of source of income,

Bank Account

Place of Employment

Other source of financial support-explain

_____ 3. I am seeking medical services to diagnose to treat pregnancy, a communicable disease (including a sexually transmitted disease) or drug or substance abuse (including alcohol).

I understand that I will be financially responsible for the charges for my medical, dental or hospital diagnosis, treatment and care and that I may not disaffirm this consent because I am a minor. I am ___ years of age, having been born on the _____________________.

Month/Day/Year
Date: ____________________________

Signature

Witness
MHA Form 10-1 - Consent for Medications

[Name of facility-psychiatric unit]

Name of Patient: ________________________________
Name of Physician: ________________________________

I authorize the administration of the following medication:

____________________________________________________________________________________

My physician has prescribed this medication for treatment of my mental health problems. My physician has discussed the nature of my emotional problems with me. My physician has told me why the above medication may be helpful.

COMMENTS: ________________________________________________________________

____________________________________________________________________________________

My physician has discussed with me effective treatment alternatives, if available.

COMMENTS: (list alternatives or write "none available")

____________________________________________________________________________________

My physician has discussed with me possible risks and side effects associated with the above medication. My physician has also discussed with me the likelihood that such risks or side effects will occur in my case. Specific risks and side effects discussed are:

____________________________________________________________________________________

I understand the amount and dosage frequency of the medication given to me may be adjusted depending on my reaction to the medication. My physician gave me an estimate of how long I will need to be on the medication, although the length of time may vary depending on my response to the medication.

I understand that I may change my decision to take the medication. I have read this form and my physician has explained to my satisfaction any questions of mine concerning the medication on this form.

__________________________________________
Date

__________________________________________
Patient or Legal Guardian or Parent of Minor

__________________________________________
Physician

__________________________________________
Witness
The Mental Health Advance Directive is made by:

Name: _______________________________________________________
Address: _____________________________________________________

I agree with the following statements:

- I am 18 years of age or older.
- A Mental Health Advance Directive provides who must be notified and/or who may visit me if I am treated for a mental disorder at an inpatient facility.
- I sign this Mental Health Advance Directive voluntarily.
- Right now, I have mental capacity to make the decisions I am making in this Mental Health Advance Directive.
- I understand this Mental Health Advance Directive will take effect if my treating mental health professional determines I have a lack of mental capacity. “Lack of mental capacity” means I do not have sufficient ability to make or communicate decisions regarding a need for treatment.
- I understand this Mental Health Advance Directive will remain in effect until one of the following occurs:
  - I revoke this Mental Health Advance Directive, orally or in writing, and the mental health professional chosen by or provided to me determines that I have sufficient mental capacity to revoke the Mental Health Advance Directive; or
  - This Mental Health Advance Directive expires by its own terms, (For example, I may choose to include an expiration date on this document); or I am no longer living.

SPECIFIC DIRECTIVES: (Do not fill in, or cross out individual sections that do not apply.)

I direct the following individual(s) shall be notified if I am treated for a mental disorder at an inpatient facility:

Name(s): _______________________________________________________
_______________________________________________________________

Address: _____________________________________________________
_______________________________________________________________

Telephone: ___________________________________________________
_______________________________________________________________

II. I direct the following individual(s) may visit me if I am being treated for a mental disorder at an inpatient facility:
Name(s) Address

__________________________  ____________________________

__________________________  ____________________________

__________________________  ____________________________

__________________________  ____________________________

III. This Mental Health Advance Directive expires as follows:

□ A. On this date: ________________________, or

□ B. When the following event occurs (describe):

________________________________________________________

________________________________________________________

________________________________________________________, or

□ C. This Mental Health Advance Directive does not expire unless I revoke it and I have sufficient mental capacity.

I sign this Mental Health Advance Directive on ____________________, 20__. 

________________________________________________________
Signature

________________________________________________________
Print name

________________________________________________________
Address

WITNESS WITNESS

Signature Signature

________________________________________________________
Print name Print name

________________________________________________________
Address Address
MHA Form 11-1 - Consent to Blood Transfusion

Name of Patient: ________________________________

Name of Physician: ________________________________

[Health Care Facility]

Date: ________________________________

Time: ______ am / pm

1. I authorize the administration of a blood transfusion to ________________________ (Myself or name of patient for whom consent is given) and such additional transfusions as may be deemed advisable in the judgment of my physician or my physician's associates or assistants. Depending on the judgment of my physician, the transfusion may be of whole blood, plasma, or some other blood product.

2. I understand certain risks are associated with the transfusion of blood products. Although transfusion is a common procedure, a serious, but rare risk is serum hepatitis, an inflammatory reaction of the liver. Serum hepatitis causes serious illness and can result in death. A common risk associated with transfusion consists of a minor, temporary reaction where the needle pierces the skin. Temporary mild skin reactions or headache may also occur.

My physician has also explained the following risks

3. I understand that blood supplied by transfusion is incidental to the provision of medical services, and no guaranty and warranty of fitness or quality applies.

4. I understand THERE IS NO ALTERNATIVE TO A TRANSFUSION if my blood level should become sufficiently depleted to require one.

I certify that I have read and understood this form, and that it has been fully explained to me if I have so requested. I certify that I am the patient, or the patient's authorized representative, and I am authorized to sign this document and accept its terms. I understand I am entitled to a copy of this document.

Date: ________________________________

______________________________
Patient

______________________________
Witness
(If the patient is unable to legally consent because he or she is a minor or is incapacitated, complete the following)
(Check if applicable)

_____ Patient is a minor ____ years of age

_____ Patient is unable to consent because ____________________________________________

________________________________________
Signature of Parent or Guardian

________________________________________
Witness
MHA Form 11-2 - Consent for Autologous Transfusion

Name: ____________________________________________

Physician: _________________________________________

[Health Care Facility]

Date: _______________ _______ am / pm

An autologous transfusion is a transfusion using blood previously drawn from the patient. The advantages, nature, and purposes of autologous transfusions, the risks involved, and the possibility of complications have been explained to me by the above-named physician. I acknowledge such counseling. Among those specific aspects of autologous transfusion that were discussed with me were the following:

- The safest blood for me to use for a transfusion is my own.

- A mild anemia and/or decrease in my blood volume may result from frequent blood donation for autologous transfusion. That because of these possible changes, I should refrain from strenuous athletic events and hazardous occupations or endeavors between the time the first unit is drawn and the scheduled use of predisposed units.

- I should contact my personal physician if I feel faint, weak, giddy, lightheaded, or dizzy.

- If the scheduled procedure is delayed for any reason it may be necessary to transfuse an older unit back to me, and withdraw a fresh unit to prevent expiration and discarding of the older unit.

- I consent to withdrawal of blood by authorized personnel for autologous transfusion purposes, and further consent to such additional procedures pursuant to autologous transfusion as may be necessary or desirable. Should I not require transfusion of the blood withdrawn for autologous transfusion, I further consent to the use or disposal of my blood in any manner deemed appropriate by the health care facility.
**I certify that I have read and understood this form, and that it has been fully explained to me if I have so requested.** I certify that I am the patient, or the patient's authorized representative, and I am authorized to sign this document and accept its terms. I understand I am entitled to a copy of this document.

Date: ________________________________

____________________________________
Patient

____________________________________
Witness

(If the patient is unable to legally consent because he or she is a minor or is incapacitated, complete the following)

(Check if applicable)

____ Patient is a minor ____ years of age

____ Patient is unable to consent because _______________________________________

____________________________________
Signature of Parent or Guardian

____________________________________
Witness
MHA Form 12-1 - Consent to Sterilization

I have asked for and received information about sterilization from ______________________ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a ___________________. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on ______________________ (Day)(Month)(Year).

I, __________________________, hereby consent of my own free will to be sterilized by ___________________________ by a method called ____________________________. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

☐ Representatives of the Department of Health and Human Services or

☐ Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

______________________________
(Signature)

______________________________
(Date)(Month)(Day)(Year).

You are requested to supply the following information, but it is not required: (Race and ethnicity designation (please check))

☐ Black (not of Hispanic origin)
Interpreter's Statement

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in ____________ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____________________________________
(Interpreter)

_____________________________________
(Date)

Statement of Person Obtaining Consent

Before _______________________________ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation ____________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____________________________________
(Signature of person obtaining consent)

_____________________________________
(Date)

_____________________________________
(Facility)

_____________________________________
(Address).
Physician's Statement

Shortly before I performed a sterilization operation upon ____________________________ (Name of individual to be sterilized) on ____________________ (Date of sterilization) ____________________________ (operation), I explained to him/her the nature of the sterilization operation ______________________ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested): Premature delivery.

Individual's expected date of delivery: ________________

☐ Emergency abdominal surgery (describe circumstances): ____________________________
________________________________________
________________________________________
________________________________________

(Physician)

(Date)
MHA Form 14-1 - Release of Health Information Concerning Inmate or Other Person in Lawful Custody
[Name of Health Care Provider]

Name of Inmate: ________________________________

Name of Correctional Institution/ Law Enforcement Official: ________________________________

Name of Requesting Individual: ________________________________

The following health information concerning the above-named inmate is requested by (“the individual”) by the above-named Correctional Institution:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

This requested information is needed for: (check all that apply)

___ 1. The provision of health care to the individual.
___ 2. The health and safety of the individual or other inmates.
___ 3. The health and safety of officers, employees, or others at the correctional institution.
___ 4. The health and safety of persons involved in transporting the individual.
___ 5. Law enforcement on the premises of the correctional institution where the individual is confined.
___ 6. The administration and maintenance of the safety, security and good order of the correctional institution.

Comments
____________________________________________________________________________________

____________________________________________________________________________________

Date _________________

Correctional Institution/ Law Enforcement Official

By: ________________________________
   (Print name)
MHA Form 15-1 - Authorization of Test on Request of Law Enforcement Officer with Subject Consent

Name of Law Enforcement Officer: __________________________________________________________

Jurisdictional Entity: __________________________________________________________
(city, county or state on behalf of which the law enforcement officer acts)

Health Care Institution from Which Test Requested: _________________________________

Name of Subject of Test: ____________________________________________________________

Procedure(s) Requested: ____________________________________________________________

Purpose of Procedure(s): ____________________________________________________________

________________________________________________________

I, ______________________________________, certify that:
(name of law enforcement officer)

(1) The subject of the requested test has been arrested;
(2) The test requested is reasonably likely to produce evidence relevant to the alleged
criminal violation underlying the arrest; and
(3) The delay in obtaining a search warrant would probably result in the destruction
of evidence

Date: ________________________________

______________________________
Signature of Law Officer:

CONSENT OF SUBJECT

I, the subject named above, do hereby consent to the above test(s) and authorize the above-
named health care personnel and institution to perform the test(s).

Date: ________________________________

______________________________
Signature of Subject:

______________________________
Witness:
This form serves to advise you that you have voluntarily consented to HIV (Human Immunodeficiency Virus) diagnostic testing and that such testing is planned during the course of your treatment. Pursuant to Montana law, you have the right to decline HIV diagnostic testing.

I have been told that the HIV test cannot tell me if I have AIDS. It can only tell me if I have HIV antibodies at the time of the test.

I have been told that a negative test means that the HIV virus was not found in my blood at this time and a positive test result means I have the HIV virus.

I have been told a negative test result does not guarantee that I am free from HIV infection. If I was recently infected with the HIV virus, I may test negative for antibodies to the virus now and I may need to be tested again.

I have been told or provided documentation describing how to prevent getting the HIV virus and how to avoid giving the virus to others.

I have been told or provided documentation stating that my HIV test result is a confidential medical record and is protected by Montana law. Medical information can be released only with my consent; or under conditions specified by the Uniform Health Care Act (Montana Code Annotated, Title 50, chapter 16).

I have been told or provided documentation stating anonymous (nameless) testing is available at several places in Montana. I can get a list of these places by calling the Montana Department of public Health and Human Services (MDPHHS) at 1-800-233-6668. This is a free call.

I have been told or provided documentation stating that all HIV test results are reported without names to the MDPHHS for statistical purposes.

I have been told or provided documentation stating that I may withdraw my consent at anytime up until blood is taken from my arm.
MHA Form 18-2 - Am I At Risk?

What is HIV (Human Immunodeficiency Virus)?
HIV is a virus. It destroys your body's ability to fight off sickness. This virus can cause AIDS. A person with HIV may not know he or she has it. The HIV virus can pass from one person to another.

How can you get HIV?
HIV is found in blood, semen ("cum"), vaginal fluids and breast milk. The virus can be passed to others through contact with any of these body fluids.

You may be at risk if now or in the past...
- You received blood or blood products before 1985.
- You have multiple sex partners
- You shoot drugs and share needles.
- You have sex with someone else who shoots drugs and shares needles
- You have unsafe sex (sex without a "rubber"/condom) with someone who has the HIV virus.
- You share used needles for tattooing or body piercing.

How can I avoid getting HIV?
Not having sex and not shooting drugs are the surest ways to prevent getting HIV.

There are other ways to reduce your risk of getting HIV.

Protect yourself if you have sex:
Use a new condom each time you have oral, anal, or vaginal sex. Latex or polyurethane is best because HIV can pass through lambskin or natural condoms.
Use water-based lubricants, like KY jelly, NOT oils or lotions, like Vaseline or Crisco that can cause a condom to break.

Protect yourself if you use drugs:
Never share drug needles or “works”
Clean drug needles with bleach, leave it sit 30 seconds, repeat 3 times, then rinse 3 times with water between uses.

Mixing sex, drugs, and alcohol is risky. If you are drunk or high it is harder to make good decisions about having sex.

Protect yourself if you are pregnant:
You can pass on HIV to your baby during pregnancy, the birth, or breastfeeding.

Medicines can lower your risk of passing your HIV to your baby during pregnancy. Ask your doctor.
You can't get HIV from hugging, kissing, sharing kitchen utensils, contact with toilets or insect bites.

You can be easily tested for HIV:
A blood test can tell you if you are infected with HIV. You can get this test without giving your name. The test is low cost or free in many places in Montana.

Who Should Get an HIV Test?
What is HIV?
HIV is a virus. It weakens your body's ability to fight off sickness. HIV is the virus that can cause AIDS. A person with HIV may not know he or she has it. HIV can pass from one person to another through blood, semen ("cum"), vaginal fluids and breast milk.

What is the test?
The only way to know whether you have HIV is by having an HIV test. It is a blood test. A small amount of blood is taken from your arm and sent to a laboratory to look for HIV antibodies. You will get the results in one to two weeks.

HIV antibodies are made when a person is infected with HIV. This test looks for HIV antibodies to learn if someone is infected.

This is not a test for AIDS. It only means that you have been infected with HIV and can develop AIDS in the future.

Should I be tested?
HIV is found in blood, semen ("cum"), vaginal fluids and breast milk. The virus can be passed to others through any of these body fluids. For HIV to pass from one person to another, the infected person's blood, semen or vaginal fluids must get in the body of another person. The HIV virus can enter through the vagina, penis, anus, mouth, or a cut in the skin.

You may need the HIV test if now, or in the past...
- You received blood or blood products before 1985.
- You have had more than one sex partner
- You shoot drugs.
- You have sex with someone else who shoots drugs.
- You have unsafe sex (sex without a "rubber"/condom) with someone who has the HIV virus.
- You are pregnant or considering pregnancy & you had sex without a condom/"rubber" with someone who may be infected or shoots drugs.
- You share tattoo or body piercing needles

What does a negative HIV test result mean?
You are probably not infected with HIV. However, since it takes the body between six weeks and six months to develop antibodies to HIV, you may test negative, even if you are infected. If you had unsafe sex (did not use a "rubber"/condom) or shared needles or "works" within the last 6 months you may need to be tested again.
Remember, until you are sure of your HIV status, protect yourself and others from HIV. A negative test does not mean that you are safe from the virus. Anyone can get HIV. If you take risks with sex or needles, you may get HIV in the future.

**What does a positive HIV test result mean?**
You are infected with HIV. This does not mean that you have AIDS.

You can give HIV to other people through unsafe sex or sharing drug needles.

You can pass HIV to your baby during pregnancy, birth or through breastfeeding.

There are programs in Montana for you if you test positive for HIV. These programs can help people with HIV stay healthy. They include medicines to help prevent infections and medicine to slow the spread of the HIV virus. Call your local health department about these programs.

Telling the people you have had sex or have shared needles with about your positive test can be difficult, so there are counselors who will help you do this.

**How can I avoid getting HIV?**
Not having sex and not sharing needles or "works" are the surest ways to prevent getting HIV. There are other ways to reduce your risk of getting HIV.

**Protect yourself if you have sex:**
Use a new condom each time you have oral, anal or vaginal sex. Latex or polyurethane is best because HIV can pass through lambskin or natural condoms.

Use water-based lubricants, like KY jelly, NOT oils or lotions, like Vaseline that can cause a condom to break more easily.

**Protect yourself if you use drugs or alcohol:**
Never share your needles or "works" to shoot drugs.

Clean needles and “works” with bleach, leave it sit 30 seconds, repeat 3 times, then rinse with water 3 times with every use.

Mixing sex, drugs, and alcohol is risky. If you are drunk or high it is harder to make good decisions about having sex.

**You can't get HIV from casual contact, such as hugging, kissing, sharing kitchen utensils, contact with toilets, or insect bites. You can't get HIV from donating blood.**

**Where can I get the HIV test?**
Most County Health Departments and Family Planning Clinics in Montana provide HIV tests and counseling. Doctors and clinics may do HIV tests too.
2 ways to get an HIV test.
You can choose the kind of test that you are most comfortable with.

ANONYMOUS
You may want to get an HIV test without giving your name. You don't have to give your name when you get a test at the places listed on the back. Results can only be given to you in person and you are the only person who will know your results.

CONFIDENTIAL
You can also get an HIV test confidentially, but your name will be recorded on your medical forms. Confidential tests are offered in many doctor's offices and clinics in Montana.

Find out before you go for an HIV test whether your name or just a code number will be used.

The Consent Form
You decide whether or not to be tested. If you choose to be tested, you will be asked to sign a consent form before being tested. If you do not get a consent form, ask for one.

For more information without giving your name, call:
Montana HIV/AIDS Hotline - 800-233-6668 - Call anytime

National AIDS Hotline - 800-342-AIDS - Call anytime.

Test Sites Where You Don't Have to Give Your Name
(Here is where the HIV Prevention Sites will be listed)

SOURCE-MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
http://vhsp.dphhs.state.mt.us/dph_r3.htm
MHA Form 18-3 - What Does It Mean?

Testing positive for HIV means that your blood has signs of the Human immunodeficiency Virus (HIV). It does not mean that you have AIDS.

A doctor needs to examine you and perform tests that will help him check your health status. Your post-test counselor can explain the test accuracy and answer any questions you may have.

Finding out you have HIV is scary. There are many support groups made up of other people in Montana who have tested positive. Call the Montana AIDS Hotline at 1-800-233-6668 to find out where to find a group.

Confidentiality (privacy)
The professionals who perform and record your test understand the need to keep your results confidential. Discuss any concerns you may have about privacy with your post-test counselor.

Early Intervention Program
Enrollment in an Early Intervention Program (EIP) can help you learn more about your infection. Drug therapies can be prescribed by your doctor in the early stages of the infection that will help to control the virus in your body. Changing risky behaviors may slow disease progression and prevent the spread of HIV.

The EIP can help you put this disease into perspective. EIP can provide you with a variety of services, including education, a medical evaluation and emotional support. This is all done in a confidential setting. EIP site numbers are on the back of this brochure.

How Is HIV Spread?
HIV is not spread by casual contact, but by certain activities. These high risk behaviors include passing semen, blood and/or vaginal secretions from an infected person to someone else. These fluids are usually passed through unprotected sexual contact or the sharing of injectable drug needles and syringes. Open sores, cuts or other skin injuries make it easier for HIV to enter into the body. Sexually transmitted diseases (STD)such as herpes and syphilis can cause sores that can help HIV infect others, or can help someone get infected if their sores come into contact with HIV infected bodily fluids. Many STD’s are treatable. See your doctor or nearest health department. Even though you are already HIV positive, you are at risk of becoming re-infected if you participate in high risk behaviors. You could be re-infected with a different strain of HIV which could be stronger than your original infection and could complicate your health care.

Protect Yourself & Others
Protect yourself if you have sex:

Use a new condom each time you have oral, anal or vaginal sex. Latex or polyurethane is best because HIV can pass through lambskin or natural condoms.

Use water-based lubricants, like KY jelly, NOT oils or lotions, like Vaseline or Crisco, that can cause a condom to break.
Protect yourself if you use drugs:

Never share drug needles or “works.”
Clean drug needles with bleach, leave them sit 30 seconds, repeat 3 times, then rinse with clean water 3 times. Do this between each use.

Mixing sex, drugs and alcohol is risky. If you are drunk or high it is harder to make good decisions about having safer sex.

Protect your baby if you are pregnant:

You can pass HIV on to your baby during pregnancy, the birth or breast feeding.

Certain medicines can lower your risk of passing your HIV to your baby during pregnancy. Ask your doctor. The only sure way to avoid passing HIV on to someone else is not to have sex or share needles or syringes. This includes tattoo or piercing needles. Ask your post-test counselor about drug treatment programs if you are ready to seek treatment.

Please do not donate blood, plasma, sperm body organs or tissues. If you are a donor on your driver’s license, have it changed, tell them you changed your mind.

Partner Notification
Since your test is positive, any sex or needle-sharing partners you may have had need to be notified and given the opportunity to receive counseling and testing. By law, public health personnel cannot tell your partner(s) your identity or the time or place of possible infection.

This is a very sensitive task. You don’t have to do this alone. Public health staff can either tell your partner(s) or help you tell them. We are here to help.

Take Charge of Your Health
Taking good care of yourself is important! Visit a doctor or clinic right away for a check up. You will need to see a health professional regularly to check on how well your body is fighting HIV.

Ask about new treatments that help people with HIV stay healthier, longer. These include the new protease inhibitors as well as other drugs that can help protect you from pneumonia and other infections.

Keep a close watch on your health between checkups. Take your meds the way they have been prescribed, if you don't you could be risking your health.

Eat healthy foods, get enough rest and talk to other HIV positive people, find out what they do to stay healthy. There is a lot to learn and your health care providers, local community based organizations and support organizations can help you find out what you need to know.

Smoking cigarettes, drinking alcohol and using drugs all can weaken your body’s defense system against disease.
Exercise can help keep you strong and help relieve stress.

Share your feelings with friends and loved ones when you are ready to do so. If you can’t do that, find a support group where you can share your feelings. This can help a lot.

So Remember:
Living with HIV is more than just medical treatment alone. It means learning to take care of your overall health.

Choose safe ways to be with a lover, so you do not pass HIV to others.

See a doctor or visit a clinic and have regular check ups. If the doctor gives you medicine, take it regularly.

Take charge of your own health. Learn to eat a healthy diet, manage your stress and exercise regularly to feel your best.

When you feel ready to do so, join a support group or talk to your friends or family. Get the support you need.

**Early Intervention Programs (EIP)**
Billings 247-3350
Deering Community Health Clinic

Bozeman 587-0681
Bridger Mountain Family Planning

Butte 723-6507
Family Services Center

Great Falls 454-6950
Cascade City-County Health Dept

Havre 265-5481
Hill County Health Dept ext 66

Helena 443-2584
Lewis & Clark Health Dept

Kalispell 758-5756
Flathead City-County Health Dept

Missoula 523-4775
Missoula City-County Health Dept
MHA Form 18-4 - About Your Negative HIV Antibody Test

What do the test results mean?
The HIV test shows if you have HIV antibodies in your blood. HIV is the virus that can cause AIDS.

A negative test means no HIV antibodies have been found in your blood at the time of your test. It can mean:

1) you are not infected with the HIV virus, or

2) you are infected, but your body has not made enough antibodies yet.
The HIV test is an extremely accurate test.

Since I tested “negative,” am I free from HIV now?
YES
If you were tested 6 months after the last time you had unsafe sex or shared needles or "works".

MAYBE
If your last unsafe act was 3 months ago or more at the time you were tested, then you are probably free from HIV. For most people, the test can find an infection if the blood sample is taken 3 months after a person got the virus.

BUT
If less than 3 months have passed since your last unsafe experience and the time of your test, the test may not find the virus, even though you are infected.

If you had an unsafe experience after the blood sample was taken, you need another test.

Do I need another test?
Answer these questions to see if you should get tested again:
In the 3 - 6 months before your test, or any time after your test, did you....

• Have unprotected sex with a person who may have HIV?
• Used drug needles or "works"?
• Fail to use condoms correctly for every sex act?
• Have an occupational (work-related) exposure to HIV?

If you answered yes to any of these questions, there's a chance you could have HIV. You should get tested again 3 to 6 months after your last unsafe experience.

How can I get HIV?
HIV is found in blood, semen ("cum") and vaginal fluids. The virus can be passed to others through any of these body fluids. For HIV to pass from one person to another, the body fluids of an infected person must get inside the body of another person. The HIV virus can enter through the vagina, penis, anus, mouth, or a cut anywhere on the body.

The more times you are exposed to HIV, the greater your chance to get the infection. **If you don't have HIV, you can stay that way by protecting yourself now.**
Don't let concerns about HIV prevent you from protecting yourself!

What can I do to keep safe from HIV?
Not having sex and not shooting drugs are the surest ways to prevent getting HIV. There are also other ways to reduce your risk of getting HIV.

Protect Yourself If You Have Sex:
Use a new condom every time you have oral, anal or vaginal sex. Latex or polyurethane is best because HIV can pass through lambskin or natural condoms.

Use water-based lubricants, like KY jelly. DO NOT use oils or lotions, like Vaseline or Crisco that can cause a condom to break.

Protect Yourself If You Use Drugs or Alcohol:
Never share needles or syringes to shoot drugs, steroids, or vitamins, or for tattooing, piercing or any other reason. Clean needles and syringes with bleach, leave it sit for 30 seconds, repeat 3 times, then rinse with water 3 times after each use. Mixing sex, drugs, and alcohol is risky. If you are drunk or high it is harder to make good decisions about having sex.

What about other sexually transmitted infections?
Most sexually transmitted infections can cause open sores or rashes in or around the vagina, penis, mouth or anus. These tiny breaks and inflammation in the skin may make it easier for HIV and other sexually transmitted infections to get into the body. Since many sexually transmitted infections can be cured, quick treatment will protect your health. Call your health care provider for more information.

Where Can I Get More Information?
If you need more information call:
Montana HIV/AIDS Hotline 1-800-233-6668 (call anytime)
National AIDS Hotline 1-800-342-AIDS (call anytime)
You don't have to give your name when you get a test at these places in Montana:

(Additional section):

How to use a condom
Step 1
Open the package. Be careful not to tear the condom. Put the condom on at the @& of sex.

Step 2
Place condom on penis and hold the tip of the condom to squeeze out the air. Roll it down the hard penis to the pubic hair. Make sure the condom does not ride up during sex. If there is no tip, leave a half-inch space at the tip for semen. Pinch it to squeeze out the air.

Step 3
If the condom is not lubricated (wet), you can put on some spermicide or KY jelly. Do NOT use oil or Vaseline. These can weaken condoms, causing them to break. If you feel a condom break during sex, stop, pull out and put on a new condom.
Step 4
After you ejaculate (cum), while the penis is still hard, hold the condom firmly at the base, close to the pubic hair. Pull out slowly. Remove the condom by rolling it off.

Step 5
Tie the condom in a knot and throw it away. Do not flush it down the toilet. Remember: Use a new condom every time you have sex-anal, oral or vaginal.

SOURCE-MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
http://vhsp.dphhs.state.mt.us/dph_r3.htm
MHA Form 18-5 – Communicable Disease Reporting Form

CONFIDENTIAL CASE REPORT

Communicable Disease Program  
Montana Department of Public Health & Human Services  
Cogswell Building, Room C-216  
Helena, MT 5962

Phone: (406) 444-0273 Fax: (800) 616-7460 Instructions: Please complete a form for each case of a communicable disease listed in 37.114.203 of the Administrative Rules of Montana (ARM).

* If you are reporting a case of Gonorrhea, Chlamydia, or Syphilis, it is necessary to complete only the back of this form.

After completion, fax or mail this form to the number or address listed above and keep a copy for your records. You may also call the above number for a list of reportable diseases, additional reporting forms, or to receive more information.

Thank you for your cooperation with disease reporting!

INDIVIDUAL CASE REPORT

<table>
<thead>
<tr>
<th>CASE INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease/Condition:</td>
</tr>
<tr>
<td>Date of Onset:</td>
</tr>
<tr>
<td>Specimen Collection Date:</td>
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<tr>
<td>Patients Name:</td>
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<tr>
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</tr>
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<td>City:</td>
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<td>Contact for more info:</td>
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Local Health Dept. Reviewer:

Montana Department of Public Health & Human Services 10/03
Complete This Side For Gonorrhea, Syphilis, or Chlamydia

CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE RECORD

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<thead>
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<th>PATIENT INFORMATION</th>
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<tbody>
<tr>
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<tr>
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<tr>
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<th>SPECIMEN COLLECTION/CLINICAL DIAGNOSIS</th>
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<td>Date Lab Specimen Collected:</td>
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<tr>
<td>Test Type: Probe EIA Culture Amplified</td>
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<tr>
<td>Date Lab Report Received:</td>
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<td>Date Reported to Health Department:</td>
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<td>Patient Diagnosis:</td>
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<tr>
<td>PID: Yes No</td>
</tr>
<tr>
<td>Health Care Provider:</td>
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<td>Phone:</td>
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<td>Provider’s Address:</td>
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<td>Date: Med: Dose: Duration:</td>
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<td>Interviewing Agency:</td>
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<td>Sex</td>
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<td>Date of Last Exposure</td>
</tr>
<tr>
<td>Test Date</td>
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<tr>
<td>Date of Treatment</td>
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<table>
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<tr>
<th>ADDITIONAL INFORMATION</th>
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<tr>
<td>Was patient counseled about HIV risk? Yes No Date if Known:</td>
</tr>
<tr>
<td>Was patient tested for HIV? Yes No Date if Known:</td>
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</table>

DISPOSITION CODES
A. Preventive Treatment D. Infected, Not Treated G. Insufficient Information to Begin Investigation K. Out of Jurisdiction
B. Refused Preventive Treatment E. Previously Treated for this Infection H. Unable to Locate
C. Infected, Brought to Treatment F. Not Infected J. Located, Refused Examination

Comments:

Local Health Department
Reviewer:
☐ New Case ☐ Update of prior report
If out of jurisdiction:
Case Referred to DPHHS ☐ or County ☐

DPHHS-STD 006 Revised 01/04
MHA Form 20-1 - Declaration Made Pursuant to the Montana Rights of the Terminally Ill Act (Living Will)

If I should have an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

I understand that I have the following rights under the Montana Rights of the Terminally Ill Act:

1. I may revoke this declaration at any time and in any manner (including but not limited to physical destruction, a signed, dated writing, or an oral expression of revocation) without regard to my mental or physical condition.

2. If my attending physician is unwilling to comply with this declaration, my physician must take all reasonable steps to transfer me to another physician who will comply with the provisions of this declaration.

3. If the policies of a healthcare facility preclude compliance with this declaration, the facility must take all reasonable steps to transfer me to a facility in which the provisions of this declaration will be carried out.

This declaration does not increase or decrease my right to make decisions regarding the use of life-sustaining procedures if I am able to do so.

Dated this ____ day of _________________, 20__. 

______________________________
Name

______________________________
Address

______________________________
City State Zip

_________________________________, a competent adult, is known to me and voluntarily signed this document in my presence.

Dated this ____ day of _________________, 20__.
<table>
<thead>
<tr>
<th>Witness</th>
<th>Witness</th>
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<tr>
<td>Address</td>
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</table>
If I should have an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I appoint ___________________________ or, if he or she is not reasonably available to serve, _______________________, to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain pursuant to the Montana Rights of the Terminally Ill Act.

If the individual I have appointed is not reasonably available or is unwilling to serve, I direct my attending physician, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

I understand that I have the following rights under the Montana Rights of the Terminally Ill Act:

1. I may revoke this declaration at any time and in any manner without regard to my mental or physical condition. Ways to revoke this declaration include physical destruction, a signed, dated writing, or an oral statement that I revoke the declaration.

2. If my attending physician is unwilling to comply with this declaration, my physician must take all reasonable steps to transfer me to another physician who will comply with the provisions of this declaration.

3. If the policies of a healthcare facility preclude compliance with this declaration, the facility must take all reasonable steps to transfer me to a facility in which the provisions of this declaration will be carried out.

This declaration does not increase or decrease my right to make decisions regarding the use of life-sustaining procedures if I am able to do so.

Dated this ____ day of _________________, 20__.  

___________________________________________  
Signature  

___________________________________________  
City, County, and State of Residence  

The declarant voluntarily signed this document in my presence.
<table>
<thead>
<tr>
<th>Witness</th>
<th>Address</th>
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<th>Witness</th>
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<table>
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<tr>
<th>Name of designee</th>
<th>Address of designee</th>
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</table>
MHA Form 20-3 - Declaration and Durable
Power of Attorney for Health Care

I, _____________________________________ of __________________________________
County, Montana, hereby appoint ____________________________________ of
___________________________ County, Montana, as my agent to make health care decisions
for me if and when I am unable to make my own health care decisions.

By this document, I intend to create a durable power of attorney for health care which shall take
effect upon my incapacity to make my own health care decisions and shall continue during that
incapacity. This gives my agent the power to consent to giving, withholding or stopping any
health care, treatment, service, or diagnostic procedure. My agent also has the authority to talk
with health care personnel, get information, and sign forms necessary to carry out these
decisions.

Notwithstanding the foregoing, if I should have an incurable and irreversible condition that,
without the administration of life-sustaining treatment, will, in the opinion of my attending
physician, cause my death within a relatively short time and I am no longer able to make
decisions regarding my medical treatment, this durable power of attorney for health care
authorizes my agent herein named to make decisions on my behalf regarding the withholding or
withdrawing of treatment that only prolongs the process of dying and is not necessary for my
comfort or to alleviate pain, pursuant to the Montana Rights of the Terminally Ill Act.

If the agents named herein are not reasonably available or are unwilling to serve, I direct my
attending physician, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or
withdraw treatment that only prolongs the process of dying and is not necessary for my comfort
or to alleviate pain.

Dated this ____ day of ____________________, 20__.

_______________________, ________________________________ County, Montana

WITNESS:
I declare that the person whose name is signed to this document is personally known to me, that
the person signed this durable power of attorney for health care in my presence, and that the
person appears to be of sound mind and under no duress, fraud or undue influence.

STATE OF MONTANA )
COUNTY OF ______________________ )

:ss.

On this__ day of ____________, 20__, before me, the undersigned, a Notary Public for
the State of Montana, personally appeared __________________________, known to me to be
the person whose name is subscribed to the within instrument and acknowledged to me that
he/she executed the same.
IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the
day and year first-above written.

(SEAL)

Notary Public for the State of Montana
Residing at: _________________________________
My Commission expires: _______________________
MHA Form 20-4 - Declaration and Durable Power of Attorney for Health Care (Including Provisions on Nutrition and Hydration)

I, ______________ of ______________________, hereby appoint my ______________, ____________________________, as my agent to make health care decisions for me if and when I am unable to make my own health care decisions.

If my ______________ is not available or is unable to act as my agent, I appoint my _________________________, ___________________________________ of _________________________, to serve as my agent to make health care decisions for me if and when I am unable to make my own health care decisions.

By this document, I intend to create a durable power of attorney for health care which shall take effect upon my incapacity to make my own health care decisions and shall continue during that incapacity. This gives my agent the power to consent to giving, withholding or stopping any health care, treatment, service, or diagnostic procedure. My agent also has the authority to talk with health care personnel, get information, and sign forms necessary to carry out these decisions.

DECLARATION GOVERNING THE WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING TREATMENT.

Notwithstanding the foregoing, if I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain, pursuant to the Montana Rights of the Terminally Ill Act as such Act exists on the date of execution of this instrument.

Treatment that may be administered for my comfort or to alleviate pain may include:

- Nutrition when administered to diminish my pain or discomfort, but not to postpone my death;
- Hydration when administered to diminish my pain or discomfort, but not to postpone my death; and
- Any other medical or nursing procedure, treatment, intervention, or other measure that is taken to diminish my pain or discomfort, but not to postpone my death.

SIGNED this _____ day of ______________, 20__.

________________________________________
Signature

________________________________________
Printed Name
WITNESSES:

I declare that the person whose name is signed to this document is personally known to me, that the person signed this durable power of attorney for health care in my presence, and that the person appears to be of sound mind and under no duress, fraud or undue influence.

WITNESS  WITNESS

________________________________________  _____________________________

STATE OF MONTANA  )
                   :ss.
County of _________________)

On this _____ day of __________, 20___, before me, the undersigned, a Notary Public for the State of Montana, personally appeared __________________________________, known to me to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year first-above written.

________________________________________
(Seal)
Notary Public for the State of Montana
Residing in ____________________________
My Commission expires: ____________________

A-63
MHA Form 21-1 - Anatomical Gift by Donor

Donor: ____________________________________________

Address: __________________________________________

In the hope that I may help others, I hereby make this anatomical gift, if medically acceptable for the purposes of transplantation or medical research, to take effect upon my death. The words and marks below indicate my desires:

I give:
(a) any needed organs or parts
(b) eyes only
(c) my body for anatomical study if needed
(d) only the following organs or parts:

__________________________________________________

__________________________________________________

Signature of Donor

Date Signed: _________________________________

City and State: ________________________________

NOTE: Complete the following only if directed by the donor and the donor is unable to sign.

I hereby sign this Anatomical gift by donor form on behalf of the donor named above, at the direction and in the presence of the donor and the witnesses named below.

Name of Individual Signing for Donor

__________________________________________________

Address

We, the witnesses identified below, hereby sign this Anatomical Gift by Donor Form as witnesses, at the direction of and in the presence of the donor and the individual signing this form at the request of the donor.

Witness

__________________________________________________

Address

Witness

__________________________________________________

Address
MHA Form 21-2 - Anatomical Gift by Relative or Other Authorized Person

[name of hospital]

Name of Decedent: _____________________________________________________________

Time and Place of Death: ______________________________________________________

Name of Relative or Other Authorized Person: ________________________________

Date: ______________  ____ am / pm

In the hope that others may be helped, I hereby make this anatomical gift with respect to the decedent named above. The words and marks below indicate the scope of this anatomical gift:

I give (check appropriate box):
(a) any needed organs or parts
(b) eyes only
(c) body for anatomical study if needed
(d) only the following organs or parts:

My relationship to the decedent is (check appropriate box):
(a) spouse
(b) adult son or daughter
(c) parent
(d) grandparent
(e) guardian

I certify that, to my knowledge no person of a nearer relationship to the decedent (in the order listed above) is available to make a decision concerning an anatomical gift with respect to the decedent, and I know of no objection to making an anatomical gift by the decedent or by a person of an equal to or nearer relationship to the decedent than myself (in the order listed above).

____________________________________________
Signature of Survivor
MHA Form 21-3 - Authority for Autopsy

DATE: ________________  _____ am / pm

In the hope that this authorization will further medical knowledge and progress, I, ________________________, being the (circle as appropriate) surviving spouse / child / parent / brother / sister / person entitled by law to control the disposition of the remains of ________________________, who died on the _____ day of _______________, 20__, in________________________ [name of hospital] _______________________, hereby authorize a post mortem examination of the decedent, including removal and retention of such specimens and tissues, as the examining physician deems proper for therapeutic or scientific purposes.

________________________________________
Signature

________________________________________
Witness

________________________________________
Witness
MHA Form 21-4 - Parents’ Authorization to Retain and Dispose of Body

We, __________________________________________, bearing the relationship of parents to baby ________________, hereby permit the release of the body of baby ________________ to the pathology staff of the laboratory at [name of hospital], for scientific purposes and study with privilege of ultimate disposal.

________________________________________________________________________
Mother’s Signature

________________________________________________________________________
Father’s Signature

WITNESSES:

________________________________________________________________________

________________________________________________________________________

DATED this ____ day of _____________, 20__. 
MHA Form 21-5 - Consent to Release Body

The undersigned being of the nearest degree of relationship* to __________________________, hereby authorize [name of hospital] _______________________, to release the body of the deceased to [name of funeral home or other authorized person] _______________________.

________________________________________
Signature

________________________________________
Relationship

Witnesses

________________________________________

*Nearest degree of relationship should be taken in the following order:

1. - Spouse of deceased
2. - Majority of adults of deceased
3. - Parent of deceased
4. - Brother or sister of deceased
5. - Personal Representative of the deceased’s estate
MHA Form 26-1 - Confidential Case Report

Communicable Disease Program Montana Department of Public Health & Human Services
Cogswell Building, Room C-216 Helena, MT 59620
Phone: (406) 444-0273 Fax: (800) 616-7460

Instructions: Please complete a form for each case of a communicable disease listed in 37.114.203 of the Administrative Rules of Montana (ARM).

*If you are reporting a case of Gonorrhea, Chlamydia, or Syphilis, it is necessary to complete only the back of this form.

After completion, fax or mail this form to the number or address listed above and keep a copy for your records. You may also call the above number for a list of reportable diseases, additional reporting forms, or to receive more information.

INDIVIDUAL CASE REPORT

CASE INFORMATION

<table>
<thead>
<tr>
<th>Disease/Condition:</th>
<th>□ Suspected</th>
<th>□ Confirmed</th>
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<tbody>
<tr>
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<td>Lab Result/Diagnosis Date:</td>
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<td>Date Reported to Health Dept:</td>
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<tr>
<td>Patients Name:</td>
<td>Occupation:</td>
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<td>County:</td>
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</table>

PROVIDER INFORMATION

Physician/Care Provider:
City:
Contact for more info:

COMMENTS:

Local Health Dept. Reviewer:

Montana Department of Public Health & Human Services 10/03
### Complete This Side For Gonorrhea, Syphilis, or Chlamydia

**CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE RECORD**

**PATIENT INFORMATION**

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<tr>
<th>Name:</th>
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<tbody>
<tr>
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<td>Sex: M F</td>
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**SPECIMEN COLLECTION/CLINICAL DIAGNOSIS**

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<td>Patient Diagnosis:</td>
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<td>Health Care Provider:</td>
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<tr>
<td>Provider’s Address:</td>
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**PATIENT TREATMENT INFORMATION**

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<th>Dose:</th>
<th>Duration:</th>
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<tr>
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<td>Med:</td>
<td>Dose:</td>
<td>Duration:</td>
</tr>
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</table>

**CONTACT INTERVIEW**

<table>
<thead>
<tr>
<th>Interviewer:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Interviewing Agency:</td>
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**CONTACT INFORMATION**

<table>
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<tr>
<th>Name of Contact</th>
<th>Sex</th>
<th>Date of Last Exposure</th>
<th>Test Date</th>
<th>Date of Treatment</th>
<th>Disposition Code (See Below)</th>
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</table>

**ADDITIONAL INFORMATION**

<table>
<thead>
<tr>
<th>Was patient counseled about HIV risk?</th>
<th>Yes</th>
<th>No</th>
<th>Date if Known:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was patient tested for HIV?</td>
<td>Yes</td>
<td>No</td>
<td>Date if Known:</td>
</tr>
</tbody>
</table>

**DISPOSITION CODES**

A. Preventive  F. Not Infected
B. Refused Preventive Treatment  G. Insufficient Information to Begin Investigation
C. Infected, Brought to Treatment  H. Unable to Locate
D. Infected, Not Treated          J. Located, Refused Examination
E. Previously Treated for this Infection       K. Out of Jurisdiction

Comments:

Local Health Department Reviewer: ________________________________

☐ New Case          ☐ Update of prior report

Out of Jurisdiction:

Case Referred to DPHHS ☐ or County ☐ ________________________________

DPHHS-STD 006 Revised 01/04
42 U.S.C.A. § 1395cc

Effective: [See Notes]

42 U.S.C.A. § 1395cc, 42 USCA § 1395cc
Effective: July 15, 2008

United States Code Annotated Currentness
Title 42. The Public Health and Welfare
Chapter 7. Social Security (Refs & Annos)
   Subchapter XVIII. Health Insurance for Aged and Disabled (Refs & Annos)
   Part E. Miscellaneous Provisions (Refs & Annos)
→ § 1395cc. Agreements with providers of services; enrollment processes

(a) Filing of agreements; eligibility for payment; charges with respect to items and services

(1) Any provider of services (except a fund designated for purposes of section 1395f(g) and section 1395n(e) of this title) shall be qualified to participate under this subchapter and shall be eligible for payments under this subchapter if it files with the Secretary an agreement--

(A)(i) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this subchapter (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this subchapter or for which such provider is paid pursuant to the provisions of section 1395f(e) of this title), and (ii) not to impose any charge that is prohibited under section 1396a(n)(3) of this title,

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this subchapter because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9) of section 1395y(a) of this title, but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter,

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person,

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this subchapter) with respect to the provider,

(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part B of subchapter XI of this chapter as may be necessary (i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such data for such purposes,

(F)(i) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b), (c), or (d) of section 1395ww of this title, to maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a utilization and quality control peer review organization which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the hospital is located, under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of
admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1395ww(d)(5) of this title, with respect to inpatient hospital services for which payment may be made under part A of this subchapter (and for purposes of payment under this subchapter, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A of this subchapter, and (I) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (II) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and (III) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1988 for direct and administrative costs (adjusted for inflation and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year) of such reviews),

(ii) in the case of hospitals, critical access hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (3)(A),

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1395ww of this title, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A of this subchapter but for a denial or reduction of payments under section 1395ww(f)(2) of this title,

(H)(i) in the case of hospitals which provide services for which payment may be made under this subchapter and in the case of rural primary care hospitals which provide rural primary care hospital services, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1395y(a)(14) of this title, and other than services described by section 1395x(s)(2)(K) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist) (I) that are furnished to an individual who is a patient of the hospital, and (II) for which the individual is entitled to have payment made under this subchapter, furnished by the hospital or otherwise under arrangements (as defined in section 1395x(w)(1) of this title) made by the hospital,

(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services--

(I) that are furnished to an individual who is a resident of the skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, that are furnished to such an individual without regard to such period), and

(II) for which the individual is entitled to have payment made under this subchapter,

(i) to adopt and enforce a policy to ensure compliance with the requirements of section 1395dd of this title and to meet the requirements of such section,

(ii) to maintain medical and other records related to individuals transferred to or from the hospital for a period of five years from the date of the transfer, and

(iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition,
(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of Title 10, or under section 1713 of Title 38, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of Title 10.

(K) not to charge any individual or any other person for items or services for which payment under this subchapter is denied under section 1320c-3(a)(2) of this title by reason of a determination under section 1320c-3(a)(1)(B) of this title,

(L) in the case of hospitals which provide inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care under section 1703 of Title 38, in accordance with such admission practices, and such payment methodology and amounts, as are prescribed under joint regulations issued by the Secretary and by the Secretary of Veterans Affairs in implementation of such section,

(M) in the case of hospitals, to provide to each individual who is entitled to benefits under part A of this subchapter (or to a person acting on the individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains--

(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this subchapter,

(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal, and which provides such additional information as the Secretary may specify,

(N) in the case of hospitals and critical access hospitals--

(i) to make available to its patients the directory or directories of participating physicians (published under section 1395u(h)(4) of this title) for the area served by the hospital or critical access hospital,

(ii) if hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the patient may receive the necessary services,

(iii) to post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying rights of individuals under section 1395dd of this title with respect to examination and treatment for emergency medical conditions and women in labor, and

(iv) to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital participates in the medicaid program under a State plan approved under subchapter XIX of this chapter,

(O) to accept as payment in full for services that are covered under this subchapter and are furnished to any individual enrolled with a Medicare+Choice organization under part C of this subchapter with a PACE provider under section 1395eee or 1396u-4 of this title, with an eligible organization with a risk-sharing contract under section 1395mm of this title, under section 1395mm(i)(2)(A) of this title (as in effect before February 1, 1985), under section 1395b-1(a) of this title, or under section 222(a) of the Social Security Amendments of 1972, which does not have a contract (or, in the case of a PACE provider, contract or other agreement)
establishing payment amounts for services furnished to members of the organization or PACE program eligible individuals enrolled with the PACE provider, the amounts that would be made as a payment in full under this subchapter (less any payments under sections 1395ww(d)(11) and 1395ww(h)(3)(D) of this title) if the individuals were not so enrolled,

(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this subchapter who require catheters, catheter supplies, ostomy bags, and supplies related to ostomy care (described in section 1395x(m)(5) of this title), to offer to furnish such supplies to such an individual as part of their furnishing of home health services,

(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) of this section (relating to maintaining written policies and procedures respecting advance directives),

(R) to contract only with a health care clearinghouse (as defined in section 1320d of this title) that meets each standard and implementation specification adopted or established under part C of subchapter XI of this chapter on or after the date on which the health care clearinghouse is required to comply with the standard or specification,

(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in an entity to which individuals are referred as described in section 1395x(ee)(2)(H)(ii), or in which such an entity has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an entity, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on--

(i) the nature of such financial interest,

(ii) the number of individuals who were discharged from the hospital and who were identified as requiring home health services, and

(iii) the percentage of such individuals who received such services from such provider (or another such provider),

(T) in the case of hospitals and critical access hospitals, to furnish to the Secretary such data as the Secretary determines appropriate pursuant to subparagraph (E) of section 1395ww(d)(12) of this title to carry out such section,

(U) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this subchapter, to be a participating provider of medical care both--

(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 1603 of Title 25), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

(ii) under any program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in section 1603 of Title 25), in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services, [FN1] and

(V) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under 18(b) [FN2] of such Act, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated).

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of subchapter XI of this chapter is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with
the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1395e(a)(1), (a)(3), or (a)(4), section 1395f(b), or section 1395x(y)(3) of this title with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B of this subchapter or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1395f(c) of this title, clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1395x(t) of this title, and with respect to clinical diagnostic laboratory tests for which payment is made under part B of this subchapter. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1395m(a) of this title, the amount of any deduction imposed under section 1395f(b) of this title and 20 percent of the payment basis described in section 1395m(a)(1)(B) of this title. In the case of items and services for which payment is made under part B of this subchapter under the prospective payment system established under section 1395f(l) of this title, clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1395f(t)(5) of this title. In the case of services described in section 1395f(t)(8) of this title or 1395f(a)(9) of this title for which payment is made under part B of this subchapter under section 1395m(k) of this title, clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge for such services 20 percent of the lesser of the actual charge or the applicable fee schedule amount (as defined in such section) for such services.

(B) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this subchapter.

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1395e(a)(2) of this title, except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this subchapter, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined), and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of this subparagraph, whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1395e(a)(2) of this title.

(D) Where a provider of services customarily furnishes items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider, notwithstanding the
preceding provisions of this paragraph, may not, under the authority of subparagraph (B)(ii) of this paragraph, charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this subchapter if the admitting physician has a direct or indirect financial interest in such provider.

(3)(A) Under the agreement required under paragraph (1)(F)(ii), the peer review organization must perform functions (other than those covered under an agreement under paragraph (1)(F)(i)) under the third sentence of section 1320c-3(a)(4)(A) of this title and under section 1320c-3(a)(14) of this title with respect to services, furnished by the hospital, rural primary care hospital, facility, or agency involved, for which payment may be made under this subchapter.

(B) For purposes of payment under this subchapter, the cost of such an agreement to the hospital, critical access hospital, facility, or agency shall be considered a cost incurred by such hospital, rural primary care hospital, facility, or agency in providing covered services under this subchapter and shall be paid directly by the Secretary to the peer review organization on behalf of such hospital, critical access hospital, facility, or agency in accordance with a schedule established by the Secretary.

(C) Such payments--

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for a fiscal year--

(I) in the case of hospitals, than the amount specified in paragraph (1)(F)(i)(III), and

(II) in the case of facilities, critical access hospitals, and agencies, than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such facilities, critical access hospitals, or agencies under part B of subchapter XI of this chapter.

(b) Termination or nonrenewal of agreements

(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary--

(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this subchapter and regulations thereunder, or with a corrective action required under section 1395ww(f)(2)(B) of this title,

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1395x of this title,

(C) has excluded the provider from participation in a program under this subchapter pursuant to section 1320a-7 or section 1320a-7a of this title, or

(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.

(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall become effective on the same date and in the same manner as an exclusion from participation under the programs under this subchapter becomes effective under section 1320a-7(e) of this title.

(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(V) of this section (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to
termination of an agreement under this section.

(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(U) [FN3] of this section by a hospital that is subject to the provisions of such Act.

(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1320a-7a of this title are imposed and collected under that section.

(c) Refiling after termination or nonrenewal; notice of termination or nonrenewal

(1) Where the Secretary has terminated or has refused to renew an agreement under this subchapter with a provider of services, such provider may not file another agreement under this subchapter unless the Secretary finds that the reason for the termination or nonrenewal has been removed and that there is reasonable assurance that it will not recur.

(2) Where the Secretary has terminated or has refused to renew an agreement under this subchapter with a provider of services, the Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under subchapter XIX of this chapter of such termination or nonrenewal.

(d) Decision to withhold payment for failure to review long-stay cases

If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1395x(fk) of this title of long-stay cases in a hospital, he may, in lieu of terminating his agreement with such hospital, decide that, with respect to any individual admitted to such hospital after a subsequent date specified by him, no payment shall be made under this subchapter for inpatient psychiatric hospital services (including inpatient psychiatric hospital services) after the 20th day of a continuous period of such services. Such decision may be made effective only after such notice to the hospital and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

(e) “Provider of services” defined

For purposes of this section, the term “provider of services” shall include--

(1) a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1395x(p)(4)(A) of this title (or meets the requirements of such section through the operation of subsection (g) or (l)(2) of section 1395x(g) of this title), or if, in the case of a public health agency, such agency meets the requirements of section 1395x(p)(4)(B) of this title (or meets the requirements of such section through the operation of subsection (g) or (l)(2) of section 1395x(g) of this title), but only with respect to the furnishing of outpatient physical therapy services (as therein defined), (through the operation of section 1395x(g) of this title) with respect to the furnishing of outpatient occupational therapy services, or (through the operation of section 1395x(l)(2) of this title) with respect to the furnishing of outpatient speech-language pathology; and

(2) a community mental health center (as defined in section 1395x(ff)(3)(B) of this title), but only with respect to the furnishing of partial hospitalization services (as described in section 1395x(ff)(1) of this title).

(f) Maintenance of written policies and procedures

(1) For purposes of subsection (a)(1)(Q) of this section and sections 1395i-3(c)(2)(E), 1395(s), 1395w-25(i), 1395mm(c)(8), and 1395bbb(a)(6) of this title, the requirement of this subsection is that a provider of services, Medicare+Choice organization, or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization--

(A) to provide written information to each such individual concerning--
(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the written policies of the provider or organization respecting the implementation of such rights;

(B) to document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual--

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a skilled nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a home health agency, in advance of the individual coming under the care of the agency,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of an eligible organization (as defined in section 1395mm(b) of this title) or an organization provided payments under section 1395l(a)(1)(A) of this title or a Medicare+Choice organization, at the time of enrollment of the individual with the organization.

(3) In this subsection, the term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(4) For construction relating to this subsection, see section 14406 of this title (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).

(g) Penalties for improper billing

Except as permitted under subsection (a)(2) of this section, any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment inconsistent with an arrangement under subsection (a)(1)(H) of this section or in violation of the requirement for such an arrangement, is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(h) Dissatisfaction with determination of Secretary; appeal by institutions or agencies; single notice and hearing

(1)(A) Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) of this section shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title, except that, in so applying such sections and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social
Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter, or both, may obtain expedited access to judicial review under the process established under section 1395ff(b)(2) of this title. Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1395i-3 of this title during the pendency of an appeal under this subparagraph.

(C)(i) The Secretary shall develop and implement a process to expedite proceedings under this subsection in which

(I) the remedy of termination of participation has been imposed;

(II) a remedy described in clause (i) or (iii) of section 1395i-3(h)(2)(B) of this title has been imposed, but only if such remedy has been imposed on an immediate basis; or

(III) a determination has been made as to a finding of substandard quality of care that results in the loss of approval of a skilled nursing facility's nurse aide training program.

(ii) Under such process under clause (i), priority shall be provided in cases of termination described in clause (i)(I).

(iii) Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1395i-3 of this title during the pendency of an appeal under this subparagraph.

(2) An institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1320a-7 of this title and this section with respect to a determination or determinations based on the same underlying facts and issues.

(i) Intermediate sanctions for psychiatric hospitals

(1) If the Secretary determines that a psychiatric hospital which has an agreement in effect under this section no longer meets the requirements for a psychiatric hospital under this subchapter and further finds that the hospital's deficiencies--

(A) immediately jeopardize the health and safety of its patients, the Secretary shall terminate such agreement; or

(B) do not immediately jeopardize the health and safety of its patients, the Secretary may terminate such agreement, or provide that no payment will be made under this subchapter with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) If a psychiatric hospital, found to have deficiencies described in paragraph (1)(B), has not complied with the requirements of this subchapter--

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the Secretary shall provide that no payment will be made under this subchapter with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no payment may be made under this subchapter with respect to any individual in the hospital until the Secretary finds that the hospital is in compliance with the requirements of this subchapter.

(j) Enrollment process for providers of services and suppliers

(1) Enrollment process

(A) In general

The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this subchapter.

(B) Deadlines

The Secretary shall establish by regulation
procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

(C) Consultation before changing provider enrollment forms

The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this subchapter.

(2) Hearing rights in cases of denial or non-renewal

A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this subchapter is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (b)(1)(A) of this section to a provider of services that is dissatisfied with a determination by the Secretary.

CREDIT(S)

2355, 2400, 2401, 2411, 2425; July 15, 2008, Pub.L. 110-275, Title I, § 143(b)(8), 122 Stat. 2543.)

[FN1] So in original. The comma probably should be preceded by a closing parenthesis.

[FN2] So in original. Probably should be preceded by “section”.

[FN3] So in original. Probably should be “(a)(1)(V)”.

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports


References in Text

Parts A and B of this subchapter, referred to in subsec. (a), are classified to 42 U.S.C.A. § 1395c et seq. and 42 U.S.C.A. § 1395j et seq., respectively.


Part B of subchapter XI of this chapter, referred to in subsec. (a)(1), (3)(C)(ii)(II), is classified to 42 U.S.C.A. § 1395c et seq.


Part C of subchapter XI of this chapter, referred to in subsec. (a)(1)(R), is classified to 42 U.S.C.A. § 1320d et seq.


Section 1395i-3(c)(2)(E) of this title, referred to in subsec. (f)(1), probably should be a reference to 42 U.S.C.A. § 1395i-3(c)(1)(E), which relates to information respecting advance directives.


301, and amended, which is classified principally to part B of this subchapter, 42 U.S.C.A. § 1395j et seq.

Codifications

Section 4157(c)(2) of Pub.L. 101-508 directed that section 1866(a)(1)(H) (42 U.S.C. 1395x(a)(1)(H)), be amended. The amendment was executed to this section as the probable intent of Congress.

Section 411(j)(5) of Pub.L. 100-360 amended section 4097(b) of Pub.L. 100-203 to correct directory language which had erroneously directed that subsec. (a)(4)(C)(ii) of this section be amended when the amendment of subsec. (a)(3)(C)(ii) of this section was intended.

Amendment by section 9122(a) of Pub.L. 99-272, which added subsec. (a)(1)(J), directed in part that the period at the end of subsec. (a)(1)(I) be struck out and “, and” be inserted and was executed to the subsec. (a)(1)(I) as added by section 9121(a) of Pub.L. 99-272 and not the subsec. (a)(1)(I) as added by section 9403(b) of Pub.L. 99-272 as the probable intent of Congress.

Section 9401 of Pub.L. 99-272, cited as a credit to this section, was enacted with two subsections (b). The first subsec. (b) of section 9401 enacted section 1320c-13 of this title, and the second subsec. (b) of section 9401 amended this section and section 1395l of this title.

Section 602(l)(1) of Pub.L. 98-21, which was to have amended subsec. (a)(1) of this section, effective Oct. 1, 1984, was repealed by Pub.L. 98-369, Title III, § 2347(a)(2), July 18, 1984, 98 Stat. 1096, effective on July 18, 1984.

Section 309(a)(5) of Pub.L. 97-448 corrected an error in the directory language of section 122(g)(5) of Pub.L. 97-248 which, as originally enacted, erroneously directed that an amendment be made to subsec. (b)(2)(A) of this section when a reference to subsec. (a)(2)(A) of this section was intended. Since the amendment by section 122(g)(5) of Pub.L. 97-248 had been executed to subsec. (a)(2)(A) of this section as the probable intent of Congress, the correction of the erroneous directory language by Pub.L. 97-448 required no change in text.

Amendments

2008 Amendments. Subsec. (e)(1). Pub.L. 110-275, § 143(b)(8), struck out “section 1395x(g) of this title” and inserted “subsection (g) or (ll)(2) of section 1395x of this title” the first two places it appeared; struck out “defined) or” and inserted “defined),” ; and inserted before the semicolon at the end the following: “, or (through the operation of section 1395x(ll)(2) of this title) with respect to the furnishing of outpatient speech-language pathology”.


Subsec. (a)(1)(O). Pub.L. 108-173, § 236(a)(1), struck out “part C of this subchapter or” and inserted “part C of this subchapter, with a PACE provider under section 1395uu of this title or 1396u-4 of this title, or”; struck out “(i)” before “with a risk sharing contract”; struck out “and (ii)” before “which does not have a contract”; inserted “(or, in the case of a PACE provider, contract or other agreement)” after “have a contract”; and struck out “members of the organization” and inserted “members of the organization or PACE program eligible individuals enrolled with the PACE provider,”.


Subsec. (a)(1)(S). Pub.L. 108-173, § 505(b)(2), struck out the period at the end and inserted “; and”.


Pub.L. 108-173, § 506(a)(2), struck out the period at the end of subsec. (a)(1)(T) and inserted “; and”.


Pub.L. 108-173, § 506(a)(2), struck out the period at the end of subsec. (a)(1)(U) and inserted “; and”.


2000 Amendments. Subsec. (a)(1)(H)(ii)(I). Pub.L. 106-554, § 1(a)(6) [Title III, § 313(b)(3)], substituted “who is a resident of the skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1395x(s)(2)(D) of this title, that are furnished to such an individual without regard to such period), and” for “who is a resident of the skilled nursing facility, and”.


Subsec. (b)(2). Pub.L. 106-113 [§ 321(k)(11)(C)] struck out the semicolon at the end and inserted a comma.


1997 Amendments. Pub.L. 105-33, § 4201(c)(1), substituted “critical access” for “rural primary care” each place it appeared.

Subsec. (a)(1). Pub.L. 105-33, § 4321(b), struck out “and” at the end of subpar. (Q), struck out the period at the end of subpar. (R), and added subpar. (S).

Subsec. (a)(1)(A). Pub.L. 105-33, § 4714(b)(1), inserted “(i)” after “(A)” and “, and (ii) not to impose any charge that is prohibited under section 1396a(n)(3) of this title” following “1395f(e) of this title),”.

Subsec. (a)(1)(H). Pub.L. 105-33, § 4432(b)(5)(F), designated existing provisions as cl. (i), redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, and inserted a new cl. (ii).

Pub.L. 105-33, § 4511(a)(2)(D), substituted “section 1395x(s)(2)(K) of this title” for “section 1395x(s)(2)(K)(i) or 1395x(s)(2)(K)(ii) of this title”.

Subsec. (a)(1)(O). Pub.L. 105-33, § 4002(e), struck out “in the case of hospitals and skilled nursing facilities,” preceding “to accept as payment in full”, “inpatient hospital and extended care” following “to accept as payment in full”, and “(in the case of hospitals) or limits (in the case of skilled nursing facilities)” following “the organization the amounts”; inserted “with a Medicare+Choice organization under part C of this subchapter or” after “any individual enrolled” and “(less any payments under sections 1395ww(d)(11) and 1395(h)(3)(D) of this title)” after “under this subchapter”.

Subsec. (a)(2)(A)(ii). Pub.L. 105-33, § 4523(b), added the penultimate sentence.

Pub.L. 105-33, § 4541(a)(3), added the last sentence.

Subsec. (b)(2). Pub.L. 105-33, § 4302(a), struck out “or” at the end of subpar. (B), struck out the period and inserted “, or” at the end of subpar. (C), and added subpar. (D).

Subsec. (f)(1). Pub.L. 105-33, § 4002(d)(1), inserted “1395w25(i),” after “1395(s),” and “, Medicare+Choice organization,” after “provider of services”.

Subsec. (f)(1)(B). Pub.L. 105-33, § 4641(a), substituted “in a prominent part of the individual's current medical record” for “in the individual's medical record”.


1994 Amendments. Subsec. (a)(1)(H). Pub.L. 103-432, § 156(a)(2), struck from the third sentence the following “, with respect to items and services furnished in connection with obtaining a second opinion required under section 1320c-13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion).”.

Subsec. (d). Pub.L. 103-432, § 106(b)(1)(B)(i) to (iv), substituted: “long-stay cases in a hospital” for “long-stay cases in a hospital or skilled nursing facility”; “such hospital” for “such hospital or facility” in two instances; “period of such services” for “period of such services or for post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be”; and “notice to the hospital” for “notice to the hospital, or (in the case of a skilled nursing facility) to the facility and the hospital or hospitals with which it has a transfer agreement,”, respectively.

Subsec. (f)(1). Pub.L. 103-432, § 160(d)(2), substituted “1395l(s)” for “1395l(r)”.

Subsec. (h)(1). Pub.L. 103-296 inserted after “section 405(g) of this title” the following “, except that, in so applying such sections and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively”.


Subsec. (a)(1)(L). Pub.L. 102-54 substituted for “Secretary of Veterans Affairs” for “Administrator of Veterans’ Affairs”.

Pub.L. 102-83 substituted “1703” for “603”.


Subsec. (a)(1)(H). Pub.L. 101-508, § 4157(c)(2), added provision excepting certain services described in section 1395x(s)(2)(K) of this title, certified nurse-midwife services, and qualified psychologist services.

Subsec. (a)(1)(I)(i). Pub.L. 101-508, § 4008(b)(3)(B), inserted “and to meet the requirements of such section” following “section 1395dd of this title”.


Subsec. (e). Pub.L. 101-508, § 4162(b)(2), designated portion of existing text as par. (1) and, in par. (1) as so designated, added provision relating to meeting of requirements through operation of section 1395x(g) of this title, wherever appearing, and added par. (2).


Subsec. (a)(1)(H). Pub.L. 101-239, § 6003(g)(3)(D)(xii)(II), inserted “and in the case of rural primary care hospitals which provide rural...
primary care hospital services” following “payment may be made under this subchapter”.


Pub.L. 101-239, § 6018(a)(1), substituted designated provisions requiring agreement to adopt and enforce policy to ensure compliance with section 1395dd requirements, to maintain transfer records for five years, and to maintain list of on-call physicians, for undesignated provision requiring agreement to comply with section 1395dd requirements to extent applicable; and made provisions applicable to rural primary care hospitals.

Subsec. (a)(1)(N). Pub.L. 101-239, § 6003(g)(3)(D)(xii)(IV), substituted “hospitals and rural primary care hospitals” and “hospital or rural primary care hospital” for “hospitals” and “hospital”, respectively.


Subsec. (a)(2)(A). Pub.L. 101-234, § 201(a)(1), deleted the amendments which had been made by sections 201(b) and (d) and 202(h)(1) of Pub.L. 100-360 and amended subpar. (A) to return it to its pre-Pub.L. 100-360 text by striking out “1395m(c),” after “1395l(b),” and “and in the case of covered outpatient drugs, applicable coinsurance percent (specified in section 1395m(c)(2)(C) of this title) of the lesser of the actual charges for the drugs or the payment limit (established under section 1395m(c)(3) of this title)” after “established by the Secretary” in the first sentence, substituting “1395l(d)(1) of this title” for “1395l(c) of this title” in the second sentence, and striking out sentence reading: A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1395l(c) of this title (relating to catastrophic benefits).”

Subsec. (a)(2)(B)(i), (ii). Pub.L. 101-239, § 6017, struck out cl. (i) designation and cl. (ii), which authorized charges for items or services more expensive than determined to be necessary and which have not been requested by the individual to the extent that such costs in the second fiscal period preceding the fiscal period in which such charges are imposed exceed necessary costs, under certain circumstances.


Subsec. (d). Pub.L. 101-234, § 101(1), deleted the amendment which had been made by section 104(d)(5) of Pub.L. 100-360 and amended subsec. (d) to return it to its pre-Pub.L. 100-360 text.


1988 Amendments. Subsec. (a)(1)(M), (N). Pub.L. 100-360, § 411(c)(2)(C), as added Pub.L. 100-485, § 608(d)(19)(A), struck out “and” at the end of subpar. (M) and struck out the period at the end of subpar. (N) and inserted a comma and “and” in lieu thereof in order to conform with the enactment of subpar. (O) by section 4012(a) of Pub.L. 100-203.

Subsec. (a)(1)(O). Pub.L. 100-360, § 411(c)(2)(A)(i), inserted “(i)” before “with a risk-sharing”, inserted in cl. (i) “, under section 1395mm(ii)(2)(A) of this title (as in effect before February 1, 1985), under section 1395b-1(a) of this title, or under section 222(a) of the Social Security Amendments of 1972, and” after “section 1395mm of this title”, and added cl. (ii).

Subsec. (a)(2)(A). Pub.L. 100-360, § 201(b), added provision that a provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1395l(c) of this title (relating to catastrophic benefits).

Pub.L. 100-360, § 201(d), substituted “In the case of items and services described in section 1395l(d)(1) of this title” for “In the case of items and services described in section 1395l(c) of this title”.
Pub.L. 100-360, § 202(h)(1), added reference to section 1395m(c) of this title, and provisions respecting covered outpatient drugs.

Pub.L. 100-360, § 411(g)(1)(D), substituted “section 1395m(a)(1)(B) of this title” for “section 1395m(a)(2) of this title”.


Subsec. (f). Pub.L. 100-485, § 608(f)(1), struck out subsec. (f), which had provided for termination or decertification and alternatives thereto.

Subsec. (g). Pub.L. 100-360, § 411(i)(4)(C)(vi), enacted section 4085(i)(28) of Pub.L. 100-203 so as to substitute reference to money penalties for reference to monetary penalties and provision that section 1320a-7a of this title (except subsecs. (a) and (b) thereof) shall apply to civil money penalties under this par. to the same extent they apply to penalties or proceedings under subsec. (a) of that section for provision that such penalties would be imposed in the same manner as civil monetary penalties were with respect to actions under subsec. (a) of that section.

1987 Amendments. Subsec. (a)(1)(F)(i)(III). Pub.L. 100-203, § 4097(a), inserted “and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year” following “(adjusted for inflation)” and substituted “1988” for “1986”.


Subsec. (a)(2)(A). Pub.L. 100-203, § 4062(d)(4), added provision authorizing a home health agency to charge individuals, with respect to items subject to payments under section 1395m(a) of this title, the amount of deductions imposed under section 1395l(b) of this title and 20 percent of payment bases described in section 1395m(a)(2) of this title.

Subsec. (a)(3). Pub.L. 100-93, § 8(d)(1), struck out former par. (3), which authorized the Secretary to refuse to enter into or renew an agreement under this section with a provider of services if any person who has direct or indirect ownership or control interest of 5 percent or more in such provider, or is an officer, director, agent, or managing employee of such provider, is a person described in section 1320a-5(a) of this title, and redesignated par. (4) as (3).

Subsec. (a)(3)(c)(ii). Pub.L. 100-203, § 4097(b), as amended by section 411(j)(5) of Pub.L. 100-360, added subcl. (I), designated existing provisions as opening cl. and subcl. (II) and, in subcl. (II) as so designated, removed references to hospitals wherever appearing. See Codification note above.

Subsec. (a)(4). Pub.L. 100-93, § 8(d)(1)(B), redesignated par. (4) as (3).

Subsec. (b)(2). Pub.L. 100-93, § 8(d)(2), substituted provision authorizing the Secretary to refuse to enter into an agreement, refuse to renew an agreement, or to terminate an agreement after the Secretary has made a specified determination of noncompliance by the provider or has excluded the provider from participation in a program under this subchapter pursuant to section 1320a-7 or 1320a-7a of this title for provision authorizing the Secretary to terminate an agreement only after making a specified determination of noncompliance by the provider.

Subsec. (b)(3). Pub.L. 100-93, § 8(d)(2), substituted provision that termination of an agreement or refusal to renew an agreement becomes effective on the same date and in the same manner as an exclusion from participation under programs under this subchapter becomes effective under section 1320a-7 of this title for provision that any termination be applicable in the case of inpatient hospital services, including inpatient psychiatric hospital services, or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date.
of such termination.

Subsec. (b)(4). Pub.L. 100-93, § 8(d)(2), struck out par. (4), which provided that any termination be applicable with respect to home health services or hospice care furnished to an individual under a plan therefor established on or after the effective date of such termination, or if a plan is established before such effective date, with respect to such services furnished to such individual more than 30 days after such effective date.

Subsec. (b)(5). Pub.L. 100-93, § 8(d)(2), struck out par. (5), which provided that any termination be applicable with respect to any other items and services furnished on or after the effective date of such termination.

Subsec. (c)(1), (3). Pub.L. 100-93, § 8(d)(3), (4), substituted “the Secretary has terminated or has refused to renew an agreement under this subchapter with a provider of services” for “an agreement filed under this subchapter by a provider of services has been terminated by the Secretary” and inserted “or nonrenewal” after “termination”.

Subsec. (c)(2). Pub.L. 100-203, § 4212(e)(4), struck out former par. (2), which provided that in the case of a skilled nursing facility participating in the programs established by this subchapter and subchapter XIX of this chapter, the Secretary may enter into an agreement under this section only if such facility has been approved pursuant to section 1396i(a) of this title, and the term of any such agreement be in accordance with the period of approval of eligibility specified by the Secretary pursuant to such section, and redesignated former par. (3) as (2).

Subsec. (c)(3). Pub.L. 100-203, § 4212(e)(4), redesignated former par. (3) as (2).

Subsec. (g). Pub.L. 100-203, § 4085(i)(17), substituted “inconsistent with an arrangement under subsection (a)(1)(H) of this section or in violation of the requirement for such an arrangement” for “for a hospital outpatient service for which payment may be made under part B and such bill or request violates an arrangement under subsection (a)(1)(H) of this section”.

Pub.L. 100-203, § 4085(i)(28), as added by Pub.L. 100-360, § 411(i)(4)(c)(vi), substituted “money” for “monetary” in the first sentence, and in the second sentence substituted provisions that section 1320a-7a of this title (other than subsec. (a) and (b) thereof) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title for provision that such penalty would be imposed in the same manner as civil monetary penalties were imposed under that section with respect to actions described in subsec. (a) of that section.


1986 Amendments. Subsec. (a)(1)(F). Pub.L. 99-509, § 9353(e)(1)(A), designated existing provisions as cl. (i), and within cl. (i) as so designated, redesignated former cls. (i) to (iii) as subcls. (I) to (III), and added cl. (ii).

Subsec. (a)(1)(F)(iii). Pub.L. 99-272, § 9402(a)(1), struck out former cl. (iii), which had provided that the cost of such agreement to the hospital would not be less than an amount which reflected the rates per review established in fiscal year 1982 for both direct and administrative costs (adjusted for inflation).

Pub.L. 99-272, § 9402(a)(2), (3) redesignated former cl. (iv) as (iii). Former cl. (iii) was struck out.


Subsec. (a)(1)(H). Pub.L. 99-509, § 9320(h)(2), added “and other than services of a certified registered nurse anesthetist”.

Pub.L. 99-509, § 9343(c)(2), struck out “inpatient hospital” following “hospitals which provide” and substituted “a patient” for “an inpatient” following “individual who is”.


Pub.L. 99-272, § 9121(a), added subpar. (I), relating to compliance, in the case of a hospital, with the
requirements of section 1395dd of this title to the extent applicable.

Pub.L. 99-272, § 9403(b), added subpar. (I), relating to agreement not to charge for certain items or services.


Subsec. (a)(1)(K). Pub.L. 99-514 redesignated subpar. (I), relating to agreement not to charge for certain items and services, as subpar. (K).


Subsec. (a)(2)(A). Pub.L. 99-272, § 9401(b)(2)(F), inserted “, with respect to items and services furnished in connection with obtaining a second opinion required under section 1320c-13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion),” after “1395x(s)(10)(A) of this title”.


Subsec. (e). Pub.L. 99-509, § 9337(c)(2), added “(or meets the requirements of such section through the operation of section 1395x(g) of this title)” after “1395x(p)(4)(A) of this title” and after “1395x(p)(4)(B) of this title” and “or (through the operation of section 1395x(g) of this title) with respect to the furnishing of outpatient occupational therapy services” following “(as therein defined)”. Pub.L. 98-369, § 2347(a)(1), substituted “maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a utilization and quality control peer review organization which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the hospital is located under which the organization” for “maintain an agreement with a utilization and quality control peer review organization (if there is such an organization which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the hospital is located) under which the organization”.

Subsec. (a)(2)(A). Pub.L. 99-509, § 9305(b)(1), substituted “maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a utilization and quality control peer review organization which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the hospital is located under which the organization” for “maintain an agreement with a utilization and quality control peer review organization (if there is such an organization which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the hospital is located) under which the organization”.

Subsec. (b)(3). Pub.L. 98-369, § 2335(d)(1), substituted “including inpatient psychiatric hospital services” for “including tuberculosis hospital services and inpatient psychiatric hospital services”.

Subsec. (b)(4)(B). Pub.L. 98-369, § 2348(a), substituted “more than 30 days after such effective date” for “after the calendar year in which such termination is effective”.

Subsec. (d). Pub.L. 98-369, § 2335(d)(2), substituted “(including inpatient psychiatric hospital services)” for “(including inpatient tuberculosis hospital services and inpatient psychiatric hospital services)”.


Subsec. (a)(1)(F). Pub.L. 98-369, § 2315(d), substituted “(b), (c), or (d)” for “(c) and (d)”. Pub.L. 98-369, § 2321(c), inserted “or which are durable medical equipment furnished as home health services” following “part B of this subchapter” in cl. (ii) of the opening sentence.

Subsec. (b)(3). Pub.L. 98-369, § 2323(b)(3), substituted “section 1395x(s)(10)(A) of this title” for “section 1395x(s)(10) of this title” following “items and services described in”. Pub.L. 98-369, § 2335(d)(2), substituted “(including inpatient psychiatric hospital services)” for “(including tuberculosis hospital services and inpatient psychiatric hospital services)”.

Subsec. (b)(4)(B). Pub.L. 98-369, § 2348(a), substituted “more than 30 days after such effective date” for “after the calendar year in which such termination is effective”.

1983 Amendments. Subsec. (a)(1). Pub.L. 98-21, § 602(l)(2), added provision at the end of par. (1) that in the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of subchapter XI terminates on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

Subsec. (a)(1)(F). Pub.L. 98-21, § 602(l)(1), which provided that, effective Oct. 1, 1984, subpar. (F) is amended by substituting “(with an organization)” for “(if there is such an organization)”, was repealed by Pub.L. 98-369, § 2347(a)(2), effective July 18, 1984.

Subsec. (a)(1)(F) to (H). Pub.L. 98-21, § 602(f)(1), added subpars. (F) to (H).


Subsec. (a)(2)(B)(ii). Pub.L. 98-21, § 602(f)(2), added “and except with respect to inpatient hospital costs with respect to which amounts are payable under section 1395ww(d) of this title” following “except with respect to emergency services” in the matter preceding subcl. (I).


Subsec. (b). Pub.L. 97-248, § 128(a)(5), in the provisions preceding par. (1), struck out “(and in the case of a skilled nursing facility, prior to the end of the term specified in subsection (a)(1) of this section)” following “may be terminated”.

Subsec. (b)(4)(A). Pub.L. 97-248, § 122(g)(6), inserted “or hospice care”.

1981 Amendments. Subsec. (a)(1). Pub.L. 97-35 struck out material following subpar. (D), which had provided that an agreement with a skilled nursing facility be for a term not exceeding 12 months with the exception that the Secretary could extend the time in specified situations.

1980 Amendments. Subsec. (a)(2)(A). Pub.L. 96-611 added provision that a provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1395x(s)(10) of this title for which payment is made under part B of this subchapter.

Subsec. (c)(3). Pub.L. 96-272 added par. (3).


1978 Amendments. Subsec. (a)(2)(A). Pub.L. 95-292 provided for the computation of and the charging of coinsurance amounts for items and services furnished individuals with end stage renal disease on the basis established by the Secretary.


Subsec. (b)(2)(C). Pub.L. 95-142, § 3(b), designated existing provision as subcl. (i) and added subcl. (ii).

Subsec. (b)(2)(F). Pub.L. 95-142, § 13(b)(3), substituted “of a quality which fails to meet professionally recognized standards of health care” for “harmful to individuals or to be of a grossly inferior quality”, and struck out provisions relating to approval by an appropriate program review team.


Subsec. (c)(2). Pub.L. 95-210 substituted “section
1396i(a) of this title” for “section 1396i of this title”.

1972 Amendments. Subsec. (a)(1). Pub.L. 92-603, §§ 227(d)(2), 249A(b), 278(a)(17), (b)(18), 281(c), substituted “Any provider of services (except a fund designated for purposes of sections 1395f(g) and 1395n(e) of this title)” for “Any provider of services” and “skilled nursing facility” for “extended care facility”, added provision that the agreement be for a term of not to exceed 12 months with an allowable extension of 2 months under specified circumstances, redesignated former subpar. (B) as (C) and added subpar. (B).

Subsec. (a)(2)(B). Pub.L. 92-603, § 223(e), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(2)(C). Pub.L. 92-603, § 223(g)(2), substituted “this subparagraph” for “clause (iii) of the preceding sentence”.


Subsec. (b). Pub.L. 92-603, §§ 229(b), 249A(c), 278(a), (17), inserted “(and in the case of an extended care facility, prior to the end of the term specified in subsection (a)(1) of this section)” in the provision preceding par. (1), in par. (2), added subpars. (D)-(F), and in par. (3), substituted “(including tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to” for “(including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to such services furnished to any individual who is admitted to the hospital or extended care facility furnishing such services on or after” and substituted “skilled nursing facility” for “extended care facility”.

Subsec. (c). Pub.L. 92-603, § 249A(d), designated existing provisions as par. (1) and added par. (2).

Subsec. (d). Pub.L. 92-603, § 278(a)(17), substituted “skilled nursing facility” for “extended care facility” and “a” for “an”.

1968 Amendments. Subsec. (a)(2)(A). Pub.L. 90-248, § 129(c)(12)(A)(i), (ii), substituted “or (a)(3)” for “, (a)(2), or (a)(4)” in cl. (i), and deleted “or, in the case of outpatient hospital diagnostic services, for which payment is made under part A” in cl. (ii).


Pub.L. 90-248, § 135(b), authorized a provider of services to charge for blood in accordance with its customary practices, included, in addition to whole blood for which a provider of services may charge, equivalent quantities of packed red blood cells, and provided that blood furnished an individual will be deemed replaced when the provider is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells) furnished the individual to which the three pint deductible applies.

Subsec. (e). Pub.L. 90-248, § 133(c), added subsec. (e).

Effective and Applicability Provisions

2008 Acts. Amendment of this section by Pub.L. 110-275, Title I, § 143, applicable to services furnished on or after July 1, 2009, see Pub.L. 110-275, Title I, § 143(c), set out as a note under 42 U.S.C.A. § 1395k.


Amendment to subsec. (a)(1)(R) to (T) of this section by Pub.L. 108-173, § 505(b), shall first apply to the wage index for discharges occurring on or after Oct. 1, 2004, see Pub.L. 108-173, § 505(e), set out as a note under 42 U.S.C.A. § 1395ww.

Pub.L. 108-173, Title V, § 506(b), Dec. 8, 2003, 117 Stat. 2295, provided that: “The amendments made by this section [amending subsec. (a)(1)(S) to (U) of this section] shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 1 year after the date of enactment of this Act [Dec. 8, 2003]) to medicare participation
agreements in effect (or entered into) on or after such date."


Pub.L. 108-173, Title IX, § 936(b), Dec. 8, 2003, 117 Stat. 2412, provided that:

“(1) Enrollment process.--The Secretary shall provide for the establishment of the enrollment process under section 1866(j)(1) of the Social Security Act [subsec. (j)(1) of this section], as added by subsection (a)(2), within 6 months after the date of the enactment of this Act [Dec. 8, 2003].

“(2) Consultation.--Section 1866(j)(1)(C) of the Social Security Act [subsec. (j)(1)(C) of this section], as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made on or after January 1, 2004.

“(3) Hearing rights.--Section 1866(j)(2) of the Social Security Act [subsec. (j)(2) of this section], as added by subsection (a)(2), shall apply to denials occurring on or after such date (not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003]) as the Secretary specifies.”

Pub.L. 108-173, Title IX, § 947(b), Dec. 8, 2003, 117 Stat. 2425, provided that: “The amendments made by this subsection (a) [amending this section] shall apply to hospitals as of July 1, 2004.”

2000 Acts. Amendment by Pub.L. 106-554, § 1(a)(6) [Title III, § 313(b)(3)], applicable to services furnished on or after Jan. 1, 2001, see Pub.L. 106-554, § 1(a)(6) [Title III, § 313(c)], set out as a note under section 1395u of this title.


1997 Acts. Amendments by section 4201 of Pub.L. 105-33 applicable to services furnished on or after October 1, 1997, see section 4201(d) of Pub.L. 105-33, set out as a note under section 1395f of this title.

Amendments by section 4302(a) of Pub.L. 105-33 effective August 5, 1997 and applicable to the entry and renewal of contracts on or after such date, see section 4302(c) of Pub.L. 105-33, set out as a note under section 1395u of this title.

Amendments by section 4321(b) of Pub.L. 105-33 effective as of date specified by the Secretary of Health and Human Services in regulations to be issued by Secretary not later than 1 year after August 5, 1997, see section 4321(d)(2) of Pub.L. 105-33, set out as a note under section 1320b-16 of this title.

Amendments by section 4432(b)(5)(F) of Pub.L. 105-33 effective for cost reporting periods beginning on or after July 1, 1998 and applicable to items and services furnished on or after such date, see section 4432(d) of Pub.L. 105-33, set out as a note under section 1395i-3 of this title.

Amendments by section 4511(a)(2)(D) of Pub.L. 105-33 applicable with respect to services furnished and supplies provided on and after January 1, 1998, see section 4511(e) of Pub.L. 105-33, set out as a note under section 1395k of this title.

Amendment by section 4541(a)(3) of Pub.L. 105-33 applicable to services furnished on or after January 1, 1999, see section 4541(e) of Pub.L. 105-33, set out as a note under section 1395l of this title.

Section 4641(b) of Pub.L. 105-33 provided that: “The amendment made by subsection (a) [amending subsec. (f)(1) of this section] shall apply to provider agreements entered into, renewed, or extended on or after such date (not later than 1 year after the date of the enactment of this Act [Aug. 5, 1997]) as the Secretary of Health and Human Services specifies.”

Amendments by section 4714(b)(1) of Pub.L. 105-33 applicable to payment for, and with respect to provider agreements relating to, items and services furnished on or after August 5, 1997, see section 4714(c) of Pub.L. 105-33, set out as a note under section 1396a of this title.

Amendment by Pub.L. 105-12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997,
for items and services provided on or after such date and to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted by such contracts, see section 11 of Pub.L. 105-12, set out as a note under section 14401 of this title.

1994 Acts. Section 106(b)(2) of Pub.L. 103-432 provided that: “The amendments made by paragraph (1) [amending this section and section 1395f of this title] shall take effect as if included in the enactment of OBRA-1987 [the Omnibus Budget Reconciliation Act of 1987, Pub.L. 100-203, 101 Stat. 1330, which was approved Dec. 22, 1987].”

Amendment by section 147(e)(7) of Pub.L. 103-432 effective as if included in the enactment of Pub.L. 101-508, 104 Stat. 1388, which was approved Nov. 5, 1990, see section 147(g) of Pub.L. 103-432, set out as a note under section 1320a-3a of this title.

Amendment by section 156(a)(2)(E) of Pub.L. 103-432 applicable to services provided on or after Oct. 31, 1994, see section 156(a)(3) of Pub.L. 103-432, set out as a note under section 1320c-3 of this title.


1990 Acts. Section 4008(b)(4) of Pub.L. 101-508 provided that: “The amendments made by this subsection [amending this section and section 1395dd of this title] shall apply to actions occurring on or after the first day of the sixth month beginning after the date of the enactment of this Act. [Nov. 5, 1990].”


Amendment by section 135(e)(7) of Pub.L. 103-432 effective as if included in the enactment of Pub.L. 101-508, 104 Stat. 1388, which was approved Nov. 5, 1990, see section 135(e)(8) of Pub.L. 103-432, set out as a note under section 1395m of this title.

Amendment by section 4157 of Pub.L. 101-508 applicable to services furnished on or after Jan. 1, 1991, see section 4157(d) of Pub.L. 101-508 set out as a note under section 1395k of this title.

Amendment by section 4162 of Pub.L. 101-508 applicable with respect to partial hospitalization services provided on or after Oct. 1, 1991, see section 4162(c) of Pub.L. 101-508, set out as a note under section 1395k of this title.

Amendment by section 4206(a) of Pub.L. 101-508 applicable with respect to services furnished on or after the first day of the first month beginning more than 1 year after Nov. 5, 1990, see section 4206(e)(1) of Pub.L. 101-508, set out as a note under section 1395i-3 of this title.

1989 Acts. Section 6018(b) of Pub.L. 101-239 provided that: “The amendments made by subsection (a) [amending this section] shall take effect on the first day of the first month that begins more than 180 days after the date of the enactment of this Act [Dec. 19, 1989], without regard to whether regulations to carry out such amendments have been promulgated by such date.”

Amendment by section 6112(e)(3) of Pub.L. 101-239 applicable with respect to items furnished on or after Jan. 1, 1990, see section 6112(e)(4) of Pub.L. 101-239, set out as a note under section 1395m of this title.


Amendment by section 201(a)(1) of Pub.L. 101-234 effective Jan. 1, 1990, see section 201(c) of Pub.L. 101-234, set out as a note under section 1395a-7a of this title.

Amendment by section 301(b) of Pub.L. 101-234 effective Dec. 13, 1989, see section 301(e)(2) of Pub.L. 101-234, set out as a note under section 1395u of this title.

Amendment by section 608(d) of Pub.L. 100-485 effective as if included in the enactment of Pub.L. 100-360, see section 608(g)(1) of Pub.L. 100-485, set out as a note under section 704 of this title.

1988 Acts. Amendment by section 608 of Pub.L. 100-485 effective as if included in the enactment of Pub.L. 100-360, see section 608(g)(1) of Pub.L. 100-485, set out as a note under section 704 of this title.

Amendment by section 608(f)(1) of Pub.L. 100-485 effective Oct. 13, 1988, see section 608(g)(2) of Pub.L. 100-485, set out as a note under section 704 of this title.

Amendment by section 104 of Pub.L. 100-360 applicable to inpatient hospital deductible for 1989 and succeeding years, care and services furnished on or after Jan. 1, 1989, premiums for January 1989 and succeeding months, and blood or blood cells furnished on or after Jan. 1, 1989, but, to the extent that the amendment eliminates the requirement that extended care services are only covered under this subchapter if they are post-hospital extended care services, to extended care services furnished pursuant to an admission to a skilled nursing facility occurring on or after Jan. 1, 1989, see section 104(a) of Pub.L. 100-360, set out as a note under section 1395d of this title.


Except as specifically provided in section 411 of Pub.L. 100-360, amendment by section 411 of Pub.L. 100-360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub.L. 100-203, effective as if included in the enactment of that provision of Pub.L. 100-203, see section 411(a)(2) of Pub.L. 100-360, set out as a Reference to OBRA, Effective Date note under section 106 of Title 1, General Provisions.

Section 411(c)(2)(A)(ii) of Pub.L. 100-360 provided that: “The amendment made by clause (i) [amending this section] shall apply to admissions occurring on or after the first day of the fourth month beginning after the date of the enactment of this Act [July 1, 1988].”

1987 Acts. Amendment by section 4012(a) of Pub.L. 100-203 applicable to admissions occurring on or after Apr. 1, 1988, or, if later, the earliest date the Secretary can provide the information required under section 4012(c) of Pub.L. 100-203 in machine readable form, see section 4012(d) of Pub.L. 100-203, set out as a note under section 1395mm of this title.

Amendment by section 4062(d)(4) of Pub.L. 100-203 applicable to covered items (other than oxygen and oxygen equipment) furnished on or after Jan. 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989, see section 4062(e) of Pub.L. 100-203, as amended, set out as a note under section 1395f of this title.

Section 4085(i)(17) of Pub.L. 100-203 provided in part that amendment by section 4085(i)(17) of Pub.L. 100-203 is effective as if included in the enactment of Pub.L. 99-509, which was approved Oct. 21, 1986.

Section 4097(c) of Pub.L. 100-203 provided that: “The amendments made by this section [amending this section] shall apply with respect to fiscal years beginning on or after October 1, 1988.”

Amendment by section 4212(e)(4) of Pub.L. 100-203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether implementing regulations are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub.L. 100-203, set out as a note under section 1396r of this title.

Amendment by Pub.L. 100-93 effective at the end of the fourteen-day period beginning on Aug. 18, 1987, and inapplicable to administrative proceedings commenced before the end of such period, see section 15(a) of Pub.L. 100-93, set out as a note under section 1320a-7 of this title.

1986 Acts. Section 233(b) of Pub.L. 99-576 provided that: “The amendments made by subsection (a) [amending this section] shall apply to inpatient hospital services provided pursuant to admissions to hospitals occurring after June 30, 1987.”

Amendment by Pub.L. 99-514 effective, unless otherwise provided, as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub.L. 99-272, which was approved Apr. 7, 1986, see section 1895(e) of Pub.L. 99-514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Section 9305(b)(2) of Pub.L. 99-509 provided that: “The Secretary of Health and Human Services shall
first prescribe the language required under section 1866(a)(1)(M) of the Social Security Act [subsec. (a)(1)(M) of this section] not later than six months after the date of the enactment of this Act [Oct. 21, 1986]. The requirement of such section shall apply to admissions to hospitals occurring on such date (not later than 60 days after the date such language is first prescribed) as the Secretary shall provide."

Amendment by section 9320(h)(2) of Pub.L. 99-509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for years 1989 through 1991 relating to the continuation of cost pass-through for certified registered nurse anesthetists, see section 9320(i), (k) of Pub.L. 99-509, set out as notes under section 1395k of this title.

Section 9332(e)(2) of Pub.L. 99-509 provided that: "The amendment made by paragraph (1) [amending this section] shall apply to agreements under section 1866(a) of the Social Security Act [subsec. (a) of this section] as of October 1, 1987."

Amendment by section 9337(c)(2) of Pub.L. 99-509 applicable to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987, see section 9337(e) of Pub.L. 99-509, set out as a note under section 1395k of this title.

Amendment by section 9343(c)(2) and (3) of Pub.L. 99-509 applicable to services furnished after June 30, 1987, see section 9343(h)(2) of Pub.L. 99-509, set out as a note under section 1395f of this title.

Section 9353(e)(3)(A) of Pub.L. 99-509 provided that: "The amendments made by paragraph (1) [amending this section] shall apply to provider agreements as of October 1, 1987."

Amendment by section 9121(a) of Pub.L. 99-272 effective the first day of the first month that begins at least 90 days after Apr. 7, 1986, see section 9121(c) of Pub.L. 99-272, set out as a note under section 1395dd of this title.

Section 9122(b) of Pub.L. 99-272, as amended Pub.L. 99-514, Title XVIII, § 1895(b)(6), Oct. 22, 1986, 100 Stat. 2933, provided that: "The amendments made by subsection (a) [amending this section] shall apply to inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987."

Section 9402(c)(1) of Pub.L. 99-272 provided that: “The amendments made by subsection (a) [amending this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986].”

Amendment by section 9403(b) of Pub.L. 99-272 effective April 7, 1986, see section 9403(c) of Pub.L. 99-272, set out as a note under section 1320c-3 of this title.

1984 Acts. Amendment by section 2303(f) of Pub.L. 98-369 applicable to clinical diagnostic laboratory tests furnished on or after July 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub.L. 98-21, set out as a miscellaneous note under section 1395y of this title, see section 2303(j)(1) and (3) of Pub.L. 98-369, set out as a note under section 1395f of this title.

Amendment by section 2315(d) of Pub.L. 98-369 applicable as though included in the enactment of the Social Security amendments of 1983, Pub.L. 98-21, which was approved Apr. 20, 1983, see section 2315(g) of Pub.L. 98-369, set out as a note under section 1395ww of this title.

Amendment by section 2321(c) of Pub.L. 98-369 applicable to items and services furnished on or after July 18, 1984, see section 2321(g) of Pub.L. 98-369, set out as a note under section 1395f of this title.

Amendment by section 2323(b)(3) of Pub.L. 98-369 applicable to services furnished on or after Sept. 1, 1984, see section 2323(d) of Pub.L. 98-369, set out as a note under section 1395f of this title.

Amendment by section 2335(d) of Pub.L. 98-369 effective July 18, 1984, see section 2335(g) of Pub.L. 98-369, set out as a note under section 1395f of this title.

Amendment by section 2347(a) of Pub.L. 98-369 effective July 18, 1984, see section 2347(d) of Pub.L. 98-369, set out as a note under section 1320c-2 of this title.

Section 2348(b) of Pub.L. 98-369 provided that: “The amendment made by this section [amending this section] shall apply to terminations issued on or after
the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2354(b)(33), (34) of Pub.L. 98-369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub.L. 98-369, set out as a note under section 1320a-1 of this title.


Amendment by section 602(f)(2) of Pub.L. 98-21 applicable, except as otherwise provided, to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after Nov. 2, 1982, to be recognized for purposes of this section only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub.L. 98-21, set out as a note under section 1395ww of this title.


Amendment by section 309(a)(5) of Pub.L. 97-448 effective as if originally included in the provision of the Tax Equity and Fiscal Responsibility Act of 1982, Pub.L. 97-248, to which such amendment relates, see section 309(c)(1) of Pub.L. 97-448, set out as a note under section 426 of this title.

Amendment by section 309(b)(11) of Pub.L. 97-448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub.L. 97-248, see section 309(c)(2) of Pub.L. 97-448, set out as a note under section 426-1 of this title.

1982 Acts. Amendment by Section 122(g)(5), (6) of Pub.L. 97-248 applicable to hospice care provided on or after Nov. 1, 1983, see section 122(h)(1) of Pub.L. 97-248, as amended, set out as a note under section 1395e of this title.

Amendment by section 128(a)(5) of Pub.L. 97-248 effective as if such amendment had been originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981 [Pub.L. 97-35], see section 128(e)(2) of Pub.L. 97-248, set out as a note under section 1395x of this title.


Amendment by section 144 of Pub.L. 97-248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub.L. 97-248, set out as a note under section 1320c of this title.

1980 Acts. Amendment by Pub.L. 96-611 effective July 1, 1981, and applicable to services furnished on or after that date, see section 2 of Pub.L. 96-611, set out as a note under section 1395I of this title.

1978 Acts. Amendment by Pub.L. 95-292 effective with respect to services, supplies, and equipment furnished after the third calendar month beginning after June 13, 1978, except that provisions for the implementation of an incentive reimbursement system for dialysis services furnished in facilities and providers to become effective with respect to a facility's or provider's first accounting period beginning after the last day of the twelfth month following the month of June 1978, and except that provisions for reimbursement rates for home dialysis to become effective on Apr. 1, 1979, see section 6 of Pub.L. 95-292, set out as a note under section 426 of this title.

1977 Acts. Section 2(f) of Pub.L. 95-210 provided that:

“(1) The amendments made by this section [amending this section and sections 1396a, 1396d, and 1396i of this title], shall (except as otherwise provided in paragraph (2) ) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act [subchapter XIX of this chapter], on and after the first day of the first calendar quarter that begins more than six months after the date of enactment of this Act [Dec. 13, 1977].
“(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [subchapter XIX of this chapter], which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title [subchapter] solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Dec. 13, 1977].”

Amendment by section 3(b) of Pub.L. 95-142 effective Oct. 25, 1977, see section 3(e) of Pub.L. 95-142, set out as a note under section 1320a-3 of this title.

Amendment by section 8(b) of Pub.L. 95-142 applicable with respect to contracts, agreements, etc., made on and after the first day of the fourth month beginning after Oct. 25, 1977, see section 8(e) of Pub.L. 95-142, set out as a note under section 1320a-5 of this title.

Amendment by section 13(b)(3) of Pub.L. 95-142 effective Oct. 25, 1977, see section 13(c) of Pub.L. 95-142, set out as a note under section 1395y of this title.

Section 15(b) of Pub.L. 95-142 provided that: “The amendments made by subsection (a) [amending subsec. (a)(1) by adding subpar. (D) of this section] shall apply with respect to agreements entered into or renewed on and after the date of enactment of this Act [Oct. 25, 1977].”

1972 Acts. Amendment by section 223(e), (g) of Pub.L. 92-603 effective with respect to accounting periods beginning after Dec. 31, 1972, see section 223(h) of Pub.L. 92-603, set out as a note under section 1395x of this title.

Amendment by section 227(d)(2) of Pub.L. 92-603 applicable with respect to accounting periods beginning after June 30, 1973, see section 227(g) of Pub.L. 92-603, set out as a note under section 1395x of this title.

Section 249A(e) of Pub.L. 92-603 provided that: “The provisions of this section [enacting section 1396i of this title and amending this section] shall be effective with respect to agreements filed with the Secretary under section 1866 of the Social Security Act [this section] by skilled nursing facilities (as defined in section 1861(j) of such Act [section 1395x(j) of this title ] before, on, or after the date of enactment of this Act [Oct. 30, 1972], but accepted by him on or after such date.”

Amendment by section 281(c) of Pub.L. 92-603 applicable in the case of notices sent to individuals after 1968, see section 281(g) of Pub.L. 92-603, set out as a note under section 1395gg of this title.

1968 Acts. Amendment by section 129(c)(12)(A), (B) of Pub.L. 90-248 applicable with respect to services furnished after Mar. 31, 1968, see section 129(d) of Pub.L. 90-248 set out as a note under section 1395d of this title.

Amendment by section 133(c) of Pub.L. 90-248 applicable with respect to services furnished after June 30, 1968, see section 133(g) of Pub.L. 90-248, set out as a note under section 1395k of this title.

Amendment by section 135(b) of Pub.L. 90-248 applicable with respect to payment for blood (or packed red blood cells) furnished an individual after Dec. 31, 1967, see section 135(d) of Pub.L. 90-248, set out as a note under section 1395e of this title.

Rule of Construction

For affect of section 143 of Pub.L. 110-275 on certain existing regulations and policies of the Centers for Medicare & Medicaid Services, see Pub.L. 110-275, § 143(d), set out as a note under 42 U.S.C.A. § 1395k.

Change of Name

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see Pub.L. 108-173, § 201, set out as a note under 42 U.S.C.A. § 1395w-21.

(a) Report.--Not later than two years after the date of the enactment of this Act [July 15, 2008], the Inspector General of the Department of Health and Human Services shall prepare and publish a report on--

(1) the extent to which Medicare providers and plans are complying with the Office for Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons and the Office of Minority Health's Culturally and Linguistically Appropriate Services Standards in health care; and

(2) a description of the costs associated with or savings related to the provision of language services.

Such report shall include recommendations on improving compliance with CLAS Standards and recommendations on improving enforcement of CLAS Standards.

(b) Implementation.--Not later than one year after the date of publication of the report under subsection (a), the Department of Health and Human Services shall implement changes responsive to any deficiencies identified in the report.

(1) In general.--The Comptroller General of the United States shall conduct a study on concierge care (as defined in paragraph (2)) to determine the extent to which such care--

(A) is used by medicare beneficiaries (as defined in section 1802(b)(5) (A) of the Social Security Act (42 U.S.C. 1395a(b)(5)(A)); and

(B) has impacted upon the access of medicare beneficiaries (as so defined) to items and services for which reimbursement is provided under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) [this subchapter].

(2) Concierge care.--In this section [this note], the term ‘concierge care’ means an arrangement under which, as a prerequisite for the provision of a health care item or service to an individual, a physician, practitioner (as described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C))), or other individual--

(A) charges a membership fee or another incidental fee to an individual desiring to receive the health care item or service from such physician, practitioner, or other individual; or

(B) requires the individual desiring to receive the health care item or service from such physician, practitioner, or other individual to purchase an item or service.

(b) Report.--Not later than the date that is 12 months after the date of enactment of this Act [Dec. 8, 2003], the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a)(1) [of this note] together with such recommendations for legislative or administrative action as the Comptroller General determines to be appropriate.”

Agreements Filed and Accepted Prior to October 30, 1972, Deemed to be for Specified Term Ending December 31, 1973

Section 249A(f) of Pub.L. 92-603 provided that: “Notwithstanding any other provision of law, any agreement, filed by a skilled nursing facility (as defined in section 1861(j) of the Social Security Act
42 U.S.C.A. § 1395cc

[section 1395x(j) of this title] ) with the Secretary under section 1866 of such Act [this section] and accepted by him prior to the date of enactment of this Act [Oct. 30, 1972], which was in effect on such date shall be deemed to be for a specified term ending on December 31, 1973.”

Delay in Implementation of Requirement That Hospitals Maintain Agreements With Utilization and Quality Control Peer Review Organization

Section 2347(b) of Pub.L. 98-369 provided that: “Notwithstanding section 604(a)(2) of the Social Security Amendments of 1983 [section 604(a)(2) of Pub.L. 98-21, set out as a note under section 1395ww of this title] the requirement that a hospital maintain an agreement with a utilization and quality control peer review organization, as contained in section 1866(a)(1)(F) of the Social Security Act [subsec. (a)(1)(F) of this section], shall become effective on November 15, 1984.”

Effect on State Law

Section 4206(c) of Pub.L. 101-508 provided that: “Nothing in subsections (a) [amending this section] and (b) [amending sections 1395l and 1395mm of this title] shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which, as a matter of conscience, cannot implement an advance directive.”

Interim Waiver in Certain Cases of Billing Rule for Items and Services Other Than Physicians' Services

For provision allowing for the waiver of the requirements of subsec. (a)(1)(H) of this section for any cost period prior to Oct. 1, 1986, where immediate compliance would threaten the stability of patient care, see section 602(k) of Pub.L. 98-21, set out as a note under section 1395y of this title.

Private Sector Review Initiative

Section 119 of Pub.L. 97-248 provided that: “(a) The Secretary of Health and Human Services shall undertake an initiative to improve medical review by intermediaries and carriers under title XVIII of the Social Security Act [this subchapter] and to encourage similar review efforts by private insurers and other private entities. The initiative shall include the development of specific standards for measuring the performance of such intermediaries and carriers with respect to the identification and reduction of unnecessary utilization of health services.

“(b) Where such review activity results in the denial of payment to providers of services under title XVIII of the Social Security Act [this subchapter], such providers shall be prohibited, in accordance with sections 1866 and 1879 of such title [this section and section 1395pp of this title], from collecting any payments from beneficiaries unless otherwise provided under such title.”

Reports to Congress on Number of Hospitals Terminating or Not Renewing Provider Agreements

Pub.L. 99-576, Title II, § 233(c), Oct. 28, 1986, 100 Stat. 3265, provided that:

“(1) The Secretary of Health and Human Services shall periodically submit to the Congress a report on the number of hospitals that have terminated or failed to renew an agreement under section 1866 of the Social Security Act as a result of the additional conditions imposed under the amendments made by subsection (a).

“(2) Not later than October 1, 1987, the Administrator of Veterans’ Affairs shall submit to the Committees on Veterans’ Affairs of the Senate and House of Representatives a report regarding implementation of this section. Thereafter, the Administrator shall notify such committees if any hospital terminates or fails to renew an agreement described in paragraph (1) for the reasons described in that paragraph.”

[For termination, effective May 15, 2000, of provisions of law requiring submittal to Congress of any annual, semiannual, or other regular periodic report listed in House Document No. 103-7 (in which item 7 on page 96 identifies a report on “Hospitals that have terminated or failed to renew an agreement under section 1866 of Social Security Act as a result of the additional conditions imposed” authorized by section 233(c) of Pub.L. 99-576, set out as a note above), see Pub.L. 104-66, § 3003, as amended, set out as a note under 31 U.S.C.A. § 1113.]
Section 9122(d) of Pub.L. 99-272 provided that: “The Secretary of Health and Human Services shall report to Congress periodically on the number of hospitals that have terminated or failed to renew an agreement under section 1866 of the Social Security Act [this section] as a result of the additional conditions imposed under the amendments made by subsection (a) [amending this section].”

[For termination, effective May 15, 2000, of provisions of law requiring submittal to Congress of any annual, semiannual, or other regular periodic report listed in House Document No. 103-7 (in which item 7 on page 96 identifies a report on “Hospitals that have terminated or failed to renew an agreement under section 1866 of Social Security Act as a result of the additional conditions imposed” authorized by section 9122(d) of Pub.L. 99-272, set out as a note above), see Pub.L. 104-66, § 3003, as amended, set out as a note under 31 U.S.C.A. § 1113.]

CROSS REFERENCES

Civil monetary penalties; improperly filed claims made pursuant to this section, see 42 USCA § 1320a-7a.

Conditions of and limitations on payment for services; requests and certifications of decision made pursuant to this section, see 42 USCA § 1395f.

Limitation of liability of beneficiaries with respect to services furnished by excluded individuals and entities, pursuant to this section, see 42 USCA § 1395y.

Payment of benefits; amount provider may charge as described in this section, see 42 USCA § 1395f et seq.

State plan for medical assistance; state power to exclude entity from participating, see 42 USCA § 1396a et seq.

CODE OF FEDERAL REGULATIONS

Detection and prevention of fraud and abuse in Medicare program, see 42 CFR § 420.1 et seq.

Hospital insurance benefits, see 42 CFR § 409.1 et seq.

Provider agreements under Medicare, see 42 CFR § 489.1.

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Patient dumping--II, the federal statute. Thomas A. Moore, 211 N.Y.L.J. 3 (Jan. 4, 1994).


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62 Am. Jur. Trials 119, Establishing Hospital Liability Under the Emergency Medical Treatment and Active Labor Act for “Patient Dumping”.

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Forms

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Social Security Law and Practice § 68:3, To Whom Part a Benefits Paid.

Social Security Law and Practice § 60:98, Limits on Beneficiary Liability.

Social Security Law and Practice § 65:44, Plan's
Satisfaction of Benefits Requirements.

Social Security Law and Practice § 60:213, Durable Medical Equipment.

West's Federal Administrative Practice § 6302, Legislation.

West's Federal Administrative Practice § 6333, Providers of Services--Qualifying to be a Provider or Supplier.

West's Federal Administrative Practice § 6334, Payments to Providers.

NOTES OF DECISIONS

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1. Agreement as prerequisite

Corporation which purchased 100% of stock of medicare provider could not recover medicare reimbursement since it did not have an agreement with the Secretary to provide medicare services as required by this section. Monterey Life Systems, Inc. v. U. S., Ct.Cl.1980, 635 F.2d 821, 225 Ct.Cl. 50. Health 535(3)

To become a provider, an entity must enter into a contract with the Secretary as specified in this section. Homan & Crimen, Inc. v. Harris, C.A.5 (Tex.) 1980, 626 F.2d 1201, rehearing denied 633 F.2d 582, certiorari denied 101 S.Ct. 1506, 450 U.S. 975, 67 L.Ed.2d 809.

This subchapter provided no room for interpretation allowing payment of benefits to nonparticipating facility. Splawn v. Schweiker, N.D.Tex.1982, 545 F.Supp. 916.

2. Cost-sharing obligations

Provision of Medicare Act requiring Medicare beneficiaries to pay 20% of reasonable charges of Part B services, which effectively resulted in beneficiaries paying more than 20% of total payment to hospital, did not require Secretary of Health and Human Services (HHS) to take action to limit Part B outpatient charges; Congress had acquiesced to Secretary's consistently held view that the provision required no action on her part. Stephenson v. Shalala, C.A.9 (Cal.) 1996, 87 F.3d 350. Health 520

Pennsylvania violated Medicare Act and buy-in provisions of Medicaid Act by paying Medicare Part B premiums, deductible, and coinsurance of qualified Medicare beneficiaries (QMBs) only to extent that amount already paid under Medicare Part B plus its payment did not exceed Medicaid allowance. Pennsylvania Medical Soc. v. Snider, C.A.3 (Pa.) 1994, 29 F.3d 886. Health 527; Health 473

New York regulation limiting state's responsibility for Medicare Part B cost-sharing coverage for patients who were “dual eligibles” or qualified Medicare beneficiaries violated Medicare and Medicaid Acts; regulation precluded providers who served dual eligibles and qualified Medicare beneficiaries pursuant to buy-in arrangement from collecting more than 80% of their reasonable costs or charges in overwhelming majority of cases. New York City Health and Hospitals Corp. v. Perales, C.A.2 (N.Y.) 1992, 954 F.2d 854, certiorari denied 113 S.Ct. 461, 506 U.S. 972, 121 L.Ed.2d 369. Health 487(4)

3. Reimbursement--Generally

Statute under which providers were eligible for Medicare reimbursement only if they executed contract with Secretary of Health and Human Services agreeing, among other things, not to charge any individual or any other person for items or services for which such individual was entitled to have payment made, did not prohibit providers from charging patients who had exhausted their Medicare hospital benefits more than Medicare-approved rates; statute did not entitle anyone to payment. Vencor, Inc. v. Physicians Mut. Ins. Co., C.A.D.C.2000, 211

Record supported finding by Secretary of Health and Human Services (HHS), in denying hospital's claim for reimbursement for bad debts related to Medicare patients in 1986 fiscal year, that hospital's asserted business reasons did not justify its noncompliance with requirement that it pursue similar practices in attempting to collect bad debts from Medicare and non-Medicare patients; although hospital submitted evidence of some increased debt collection costs in 1989-1991 fiscal years, in which hospital did pursue same debt collection practices for both types of patients, it did not conclusively demonstrate that these increased costs would have been incurred in 1986 if both types of accounts had been treated similarly. University Health Services, Inc. v. Health & Human Services, C.A.11 (Ga.) 1997, 120 F.3d 1145, certiorari denied 118 S.Ct. 2059, 524 U.S. 904, 141 L.Ed.2d 137. Health 541

Statute governing payment for costs of review by Peer Review Organizations (PROs) of services of hospitals that participate in Medicare program, provides that Secretary of Health and Human Services pay PROs directly for the cost of their review, rather than that Secretary pay hospitals their PRO review costs on rate per review basis. Queen of Angels/Hollywood Presbyterian Medical Center v. Shalala, C.A.9 (Cal.) 1995, 65 F.3d 1472. Health 535(1)

Funds in Medicare provider's funded depreciation account were not “contractually committed” to making $1.5 million balloon payment on bond issue, so that there was no “financial need” for Medicare provider's borrowing of at least $1.5 million of the debt for which reimbursable interest expenses were claimed, where no evidence was presented that this $1.5 million was segregated in separate account or that funds were held pursuant to any restrictions to ensure that balloon payment was made. Sentara-Hampton General Hosp. v. Sullivan, C.A.D.C.1992, 980 F.2d 749, 298 U.S.App.D.C. 372. Health 535(4)

The hospital was entitled as a nonprofit provider of services under this subchapter to full reimbursement for the portion of emergency room costs allocable to Medicare without an offset for two “restricted grants” where payments in form of grants to hospital by local county government bodies to assure continued operation of emergency facility were not restricted in sense of the pertinent regulation and the “Providers Manual” because there was nothing in the grants providing that they “must be used only for the specific purpose designated by the donor.” Milford Memorial Hospital, Inc. v. U. S., Ct.Cl.1982, 675 F.2d 270, 230 Ct.Cl. 76. Health 535(4)

Amounts which nonprofit hospital-medical insurer, which contracted to administer medicare program, paid local nonprofit federation as insurer's share of health care planning expense was not a “contribution” or “donation” for which it could not receive reimbursement from government, since insurer received business benefits, even though payment to federation entitled federation to matching federal grant. Blue Cross Ass'n v. U. S., Ct.Cl.1973, 474 F.2d 654, 200 Ct.Cl. 716. United States 70(15.1)

All state limitations on providers' rights to recover their reasonable costs and charges for furnishing services to Medicare-eligible patients, including patients duly eligible under Medicare and Medicaid and other “Qualified Medicare Beneficiaries” (QMBs) under Medicare “Part B,” are unlawful. Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski, E.D.Va.1993, 838 F.Supp. 243, affirmed 42 F.3d 1444, certiorari denied 116 S.Ct. 60, 516 U.S. 811, 133 L.Ed.2d 23. Health 535(4)

4. ---- Regulations, reimbursement

Secretary of Health and Human Services (HHS) did not engage in unfair, retroactive rulemaking by denying hospital's claim for reimbursement for bad debts related to Medicare patients, even though such denial was based on fact that hospital pursued different collection efforts as to non-Medicare accounts, and even though fiscal intermediary allowed hospital's reimbursement claims in previous years in which hospital had same collection policy in force; intermediary did not discover hospital's bad debt collection practices and its concomitant noncompliance with applicable requirements until intermediary conducted audit in fiscal year that hospital's claim was denied. University Health Services, Inc. v. Health & Human Services, C.A.11 (Ga.) 1997, 120 F.3d 1145, certiorari denied 118 S.Ct. 2059, 524 U.S. 904, 141 L.Ed.2d 137. Social Security And Public Welfare 6; Health 541
5. Lien on injury recoveries

Under its agreement with medicare, hospital which provided medical care to social security recipient for accident injuries could not file lien on recipient's personal injury settlement for shortage on charges for covered services for which hospital billed medicare, except for deductible or coinsurance amounts, since payment of hospital's charges by medicare, though less than actual bills, extinguished recipient's debt to hospital. Holle v. Moline Public Hosp., C.D.Ill.1984, 598 F.Supp. 1017.

6. Termination of agreement

Where Department notified owners and operators of licensed health care facilities on Mar. 1, 1978, that it would not renew medicare provider agreement for period commencing Apr. 1, 1978, owners and operators were provided with 69-page report detailing alleged deficiencies in facilities and were given opportunity to reply to such report, there was a reinspection of facilities by two allegedly disinterested inspectors, and owners and operators made appearance before decision maker to argue their position, termination of Medicare provider agreement complied with due process. Schwartzberg v. Califano, S.D.N.Y.1978, 453 F.Supp. 1042. Constitutional Law 4127

7. Presentation of claim

Where hospital administrator demanded immediate rescission of hospital's medicare provider termination order on ground that cited deficiencies did not affect quality of care provided by hospital or safety of its patients, although administrator did not deny existence of life safety code violations, administrator's general challenge to termination decision was inadequate to meet presentation of claim which is prerequisite to final decision of Secretary of Health and Human Services. Northlake Community Hospital v. U.S., C.A.7 (Ill.) 1981, 654 F.2d 1234. Health 537

8. Notice and hearing

Decision of Secretary of Department of Health and Human Services and insurance carrier to suspend medicare reimbursements to clinic pending administrative hearing did not violate due process, despite clinic's contention that it would go out of business if carrier continued to withhold reimbursement monies. Karnak Educational Trust v. Bowen, C.A.11 (Fla.) 1987, 821 F.2d 1517.

Skilled nursing facility was not entitled to administrative hearing before ban on medicare reimbursement, complete with presiding administrative law judge and opportunity to cross-examine witnesses when less severe sanction is imposed; Secretary of Health and Human Services complied with statutory requirements by affording facility opportunity to present its plan of correction and to seek clarification of described deficiencies at informal hearings. Patchogue Nursing Center v. Bowen, C.A.2 (N.Y.) 1986, 797 F.2d 1137, certiorari denied 107 S.Ct. 873, 479 U.S. 1030, 93 L.Ed.2d 828. Health 548

Where medicare provider was first notified that it was not in compliance with medicare physical environment conditions eight months before provider agreement was terminated, provider was issued warning that provider's agreement would be terminated, but it was not until six months after receipt of termination warning that medicare provider reported to Department of Health and Human Services on status of deficiencies, and shortly thereafter, Secretary of Health and Human Services notified provider that its provider agreement would be terminated, and termination letter as well as termination warning listed deficiencies which caused termination of agreement, provider had adequate notice of deficiencies which caused termination. Northlake Community Hospital v. U.S., C.A.7 (Ill.) 1981, 654 F.2d 1234. Health 537

Nursing home, whose provider agreement was to expire Aug. 31, 1979, and contained no provision as to renewal, had at most a unilateral hope that new provider agreements would be executed, and such unilateral hope could not constitute a protected "property interest" as would require hearing before government suspended nursing home from participation in medicaid program. Geriatrics, Inc. v. Harris, C.A.10 (Colo.) 1981, 640 F.2d 262, certiorari denied 102 S.Ct. 129, 454 U.S. 832, 70 L.Ed.2d 109. Health 505(2)

Secretary of Health and Human Services, in imposing ban on medicare and medicaid admissions to nursing facility, violated Social Security Act section [42
U.S.C.A. § 1395cc(f)(2)] by failing to provide nursing home with an adequate informal preban hearing and adequate notice of the charges, where nursing home was not provided with a copy of survey report upon which decision was based and was not given an opportunity for an informal hearing following the survey. Nassau Nursing Home v. Heckler, E.D.N.Y.1985, 614 F.Supp. 1091. Health § 548; Health § 502

9. Exhaustion of administrative remedies

Medical service provider was required to exhaust its administrative remedies in response to Health Care Financing Administration's (HCFA) revocation of its certification to perform laboratory testing, before bringing due process challenge against cancellation of Medicare eligibility that accompanied revocation; although economic impact of Medicare ineligibility was significant, provider's financial need to be subsidized for care of its Medicare patients was only incidental to purpose and design of Medicare program, risk of erroneous deprivation of provider status was quite manageable, and government had strong interest in expediting provider-termination procedures. Oakland Medical Group, P.C. v. Secretary of Health and Human Services, Health Care Financing Admin., C.A.6 (Mich.) 2002, 298 F.3d 507. Health § 556(3)

Failure to exhaust administrative remedies precluded grant of temporary restraining order continuing financing of nursing home by Centers for Medicare and Medicaid Services (CMS), during pendency of administrative appeal of decision by Georgia Department of Human Resources (DHR), to close facilities for nonconformity with Medicare and Medicaid requirements, despite claim that suit involved issue of whether Medicare and Medicaid provider agreements could be terminated, to which exhaustion requirement did not apply. Forum Healthcare Group, Inc. v. Centers For Medicare and Medicaid Services, N.D.Ga.2007, 495 F.Suppd. 1321. Health § 509; Health § 556(3)

Operator of skilled nursing facilities was required to exhaust administrative remedies before filing suit to challenge termination of its participation in Medicare and Medicaid programs, even if its judicial challenge was based on constitutional and statutory provisions beyond jurisdiction of administrative tribunal, and it faced irreparable harm as result of termination; favorable judicial resolution of operator's claim would have resulted in same resolution it sought in administrative appeal. Trade Around World of PA v. Shalala, W.D.Pa.2001, 145 F.Supp.2d 653. Health § 509

Claim “arises under” Medicare Act, so that administrative remedies under Act must be exhausted before action may be filed in federal court, when both standing and substantive basis for presentation of claims is the Medicare Act. Ancillary Affiliated Health Services, Inc. v. Shalala, E.D.Wis.1998, 994 F.Supp. 1006, affirmed 165 F.3d 1069. Health § 556(3)

This chapter provides entirely different review process for claims brought by providers of Medicare services, regarding aspects of reimbursement, than it does from initial determination as to whether petitioner is in fact provider of Medicare services, and thus provider of Medicare services was not required to exhaust administrative remedies pertaining to determinations of providers where its claim was for reimbursement. Humana of South Carolina, Inc. v. Mathews, D.C.D.C.1976, 419 F.Supp. 253, affirmed in part, reversed in part 590 F.2d 1070, 191 U.S.App.D.C. 368. Health § 556(3)

10. Private cause of action

Medicare statute prohibiting “balance billing” for services for which patient is entitled to Medicare payment does not create implied private right of action on behalf of patient or patient's representative against provider who violates provision. Wentz v. Kindred Hospitals East, L.L.C., S.D.Fla.2004, 333 F.Supp.2d 1298. Health § 556(1)


11. Judicial review

Court of Appeals was not required to review whether some additional costs of hospitals incurred in participating in review by Peer Review Organizations (PROs) are not covered under Medicare payments, on
review of whether statute governing payment for costs of review by PROs, provided for payment to PROs or to hospitals, since review of scope of reimbursements was limited to determining whether Secretary of Health and Human Services could explain her interpretation of statute in general context of Medicare reimbursement scheme. Queen of Angels/Hollywood Presbyterian Medical Center v. Shalala, C.A.9 (Cal.) 1995, 65 F.3d 1472. Health 535(1)

Claim that fiscal intermediaries acted beyond their authority in representing to medicare provider that interest on mortgage loans was reimbursable was not reviewable by the Court of Appeals under its pendent appellate jurisdiction when claim of absolute immunity which was subject of appeal from denial of summary judgment was otherwise unappealable because not a claim separable from, and collateral to, rights asserted in action. Group Health Inc. v. Blue Cross Ass'n, C.A.2 (N.Y.) 1986, 793 F.2d 491, certiorari denied 107 S.Ct. 1566, 480 U.S. 930, 94 L.Ed.2d 758.

Nurses' association's action seeking declaratory judgment that Department of Health and Human Services (HHS) had violated Medicare Act by delegating to private entity its responsibility for adequate registered nurse staffing at Medicare-participating hospitals, resulting in understaffing, was cognizable under Administrative Procedure Act (APA); association challenged method by which HHS' determinations of Medicare participation were made, rather than questioning whether specific facility was in compliance with conditions of participation. American Nurses Ass'n v. Leavitt, D.D.C.2009, 593 F.Supp.2d 126. Health 556(1)


12. Mandamus

District court did not have mandamus jurisdiction over actions brought by skilled nursing facilities challenging termination of their medicare provider status without pretermination hearings, since this subchapter did not create a clear right on part of nursing facilities to pretermination hearings in situations in which Secretary of Health and Human Services determined that facilities' deficiencies placed patients' health and safety in "immediate jeopardy," and absent such a clear right to pretermination hearings, mandamus jurisdiction was not appropriate. Americana Healthcare Corp. v. Schweiker, C.A.7 (Ind.) 1982, 688 F.2d 1072, certiorari denied 103 S.Ct. 1187, 459 U.S. 1202, 75 L.Ed.2d 434, Mandamus 81

13. Moot questions

Health and Human Services Secretary's appeal from district court's orders prohibiting Secretary from terminating skilled nursing facilities' participation in medicare program without affording facilities an opportunity for pretermination hearing was not rendered moot as result of fact that facilities had been recertified for medicare participation, since resolution of issues presented was necessary to proper determination of question of whether nursing facilities were validly decertified, and resolution of the issues served public interest by resolving issues which otherwise were likely to recur. Americana Healthcare Corp. v. Schweiker, C.A.7 (Ind.) 1982, 688 F.2d 1072, certiorari denied 103 S.Ct. 1187, 459 U.S. 1202, 75 L.Ed.2d 434. Federal Courts 724
§ 1395dd. Examination and treatment for emergency medical conditions and women in labor

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless--

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the
individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer--

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility--

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who--

(i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section, is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a-7a of this title (other than the
first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a-7(a)(1) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with peer review organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this subchapter, the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of subchapter XI of this chapter) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B of subchapter XI of this chapter.

(4) Notice upon closing an investigation

The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

(e) Definitions

In this section:

(I) The term "emergency medical condition" means--

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in--

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious
jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions--

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means a hospital that has entered into a provider agreement under section 1395cc of this title.

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a critical access hospital (as defined in section 1395x(mm)(1) of this title).

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

CREDIT(S)

42 U.S.C.A. § 1395dd, 42 USCA § 1395dd


[FN1] So in original. Probably should be followed by a comma.

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports


References in Text


Part B of subchapter XI of this chapter, referred to in subsec. (d)(3), is classified to section 1320c et seq. of this title.

Amendments


Subsec. (d)(3). Pub.L. 108-173, § 944(c)(1), in the first sentence, inserted "or in terminating a hospital's participation under this subchapter" following "in imposing sanctions under paragraph (1)"; and added at the end the following: "Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such a review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such
part B."


Subsec. (e)(2).  Pub.L. 108-173, § 736(a)(14)(C), struck out "means hospital" and inserted "means a hospital".

1997 Amendments. Subsec. (e)(5). Pub.L. 105-33, § 4201(c)(1), substituted "critical access" for "rural primary care" each place it appeared.

1994 Amendments. Pub.L. 103-432, § 160(d)(4), substituted "4207" for "4027" as the section number of the section of Pub.L. 101-508 which had amended this section in 1990. This substitution of section numbers served to remove a technical error in the section numbering scheme of Pub.L. 101-508 but otherwise resulted in no changes in text.

Pub.L. 103-432, § 160(d)(5)(A), corrected a technical error in the directory language of section 4207(a)(1) of Pub.L. 101-508 which had amended this section in 1990. Amendment resulted in no change in text.


Subsec. (d)(1)-(3). Pub.L. 101-508, § 4008(b)(3)(A)(ii), (ii), redesignated former pars. (2) and (3) as (1) and (2), respectively. Former par. (1), which authorized termination or suspension of Medicare provider agreement for failure to meet section requirements, was struck out.

Subsec. (d)(2). Pub.L. 101-508, § 4008(b)(1), made provisions applicable to negligent rather than to knowing violations of section requirements.

Pub.L. 101-508, § 4207(a)(3), substituted "is gross and flagrant or is repeated" for "knowing and willful or negligent" in the provisions following cl. (i).


Subsec. (i). Pub.L. 101-508, § 4207(k)(3), substituted "against a qualified medical person described in subsection (c)(1)(A)(iii) of this section or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section" for "against a physician because the physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized".


Subsec. (a). Pub.L. 101-239, § 6211(a), substituted "hospital's emergency department, including ancillary services routinely available to the emergency department," for "hospital's emergency department".

Pub.L. 101-239, § 6211(h)(2)(B), struck out material requiring medical screening to determine if individual is in active labor as defined under subsec. (e)(2).

Subsec. (b). Pub.L. 101-239, § 6211(h)(2)(C) in heading, substituted "labor" for "active labor".

Subsec. (b)(1). Pub.L. 101-239, § 6211(b)(2)(D), in opening par. substituted "emergency medical condition" for "emergency medical condition or is in active labor".

Subsec. (b)(1)(A). Pub.L. 101-239, § 6211(h)(2)(D), substituted "stabilize the medical condition" for "stabilize the medical condition or to provide for treatment of the labor".

Subsec. (b)(2). Pub.L. 101-239, § 6211(b)(1)(A), substituted "in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the" for "in that paragraph but the".
"consent to the examination and treatment" for "consent to the examination or treatment".

Pub.L. 101-239, § 6211(b)(1)(C), added material providing hospital should take reasonable steps to obtain written informed consent to refuse examination and treatment.

Subsec. (b)(3). Pub.L. 101-239, § 6211(b)(2)(A), substituted "with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer," for "with subsection (c) of this section".

Pub.L. 101-239, § 6211(b)(2)(B), added material providing hospital should take all reasonable steps to obtain written informed consent to refuse transfer.


Pub.L. 101-239, § 6211(g)(1)(B) substituted "an individual", "the individual", "individual's" and "individuals" for "a patient", "the patient", "patient's", and "patients" each place each appears, respectively.

Subsec. (c)(1). Pub.L. 101-239, § 6211(c)(4), added material providing that certification under subpar. (A)(ii) or (iii) include a summary of risks and benefits upon which certification is based.

Pub.L. 101-239, § 6211(h)(2)(E), substituted "(within the meaning of subsection (e)(3)(B) of this section) for "(within the meaning of subsection (e)(4)(B) of this section) or is in active labor".

Subsec. (c)(1)(A)(i). Pub.L. 101-239, § 6211(c)(1), substituted "after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility" for "requests that the transfer be effected".

Subsec. (c)(1)(A)(ii). Pub.L. 101-239, § 6211(c)(2)(B)(i), struck out material allowing other qualified medical personnel to certify a patient transfer when a physician is not available.

Pub.L. 101-239, § 6211(c)(2)(B)(ii), substituted "information available at the time of transfer," for "information available at the time, ".

Pub.L. 101-239, § 6211(c)(3)(A), substituted "has signed a certification that based upon the information" for "has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information".

Pub.L. 101-239, § 6211(c)(3)(B), substituted "risks to the individual and, in the case of labor, to the unborn child" for "risks to the individual's medical condition".


Subsec. (c)(2)(A). Pub.L. 101-239, § 6211(c)(5), added subpar. (A). Former subpar. (A) was redesignated as (B).

Subsec. (c)(2)(B). Pub.L. 101-239, § 6211(c)(5)(A), redesignated former subpar. (A) as (B). Former subpar. (B) was redesignated as (C).

Subsec. (c)(2)(C). Pub.L. 101-239, § 6211(c)(5)(A), redesignated former subpar. (B) as (C). Former subpar. (C) was redesignated as (D).

Pub.L. 101-239, § 6211(d)(1), substituted "transferring hospital sends to the receiving facility" for "transferring hospital provides the receiving facility".

Pub.L. 101-239, § 6211(d)(2), substituted material detailing information to be included in transferred medical records including certification for transfer and name and address of any physician who failed to meet certain standards, for material requiring transferring hospital to provide receiving facility with appropriate medical records.

Subsec. (c)(2)(D). Pub.L. 101-239, § 6211(c)(5)(A), redesignated former subpar. (C) as (D). Former subpar. (D) was redesignated as (E).


Subsec. (d)(2)(B). Pub.L. 101-239, § 6211(e)(1), substituted material relating to particular physicians and their responsibilities for examination, treatment and transfer of patients, providing certain civil penalties if standards are violated, including exclusion from State health care programs if violation knowing and willful or negligent, for material providing certain sanctions and civil penalties.

added subpar. (C). Former subpar. (C), which defined "responsible physician" as one who was employed by or under contract with the hospital and acting in that capacity had professional responsibility for service rendered to which violation related, was struck out.

Subsec. (e)(1). Pub.L. 101-239, § 6211(h)(1)(A), redesignated portion of opening par. as subpar. (A), redesignated former subpar. (A) as cl. (i) and, in cl. (i) as so redesignated, added parenthetical material related to the health of a pregnant woman or unborn child, redesignated subpars. (B) and (C) as clss. (ii) and (iii), respectively, and added subpar. (B).

Subsec. (e)(2). Pub.L. 101-239, § 6211(h)(1)(B), struck out par. (2) which contained material defining "active labor".

Pub.L. 101-239, § 6211(h)(1)(E), redesignated former par. (3) as (2).

Subsec. (e)(3). Pub.L. 101-239, § 6211(h)(1)(E), redesignated former par. (4) as (3). Former par. (3) was redesignated as (2).

Subsec. (e)(4). Pub.L. 101-239, § 6211(h)(1)(E), redesignated former par. (5) as (4). Former par. (4) was redesignated as (3).


Pub.L. 101-239, § 6211(h)(1)(C)(ii), substituted "likely to result from or occur during" for "likely to result from".

Pub.L. 101-239, § 6211(h)(1)(C)(iii), substituted "from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta)" for "from a facility".

Subsec. (e)(4)(B). Pub.L. 101-239, § 6211(h)(1)(D), inserted "described in paragraph (1)(A)" after "emergency medical condition", "or occur during" after "to result from", and ", or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta)" after "from a facility".

Subsec. (e)(5). Pub.L. 101-239, § 6211(g)(2), substituted "an individual" for "a patient" wherever appearing.

Subsec. (e)(6). Pub.L. 101-239, § 6211(h)(1)(E), redesignated former par. (6) as (5). Former par. (5) was redesignated as (4).


Subsecs. (g) to (i). Pub.L. 101-239, § 6211(f), added subsecs. (g), (h) and (i).

1988 Amendments. Subsec. (d)(2). Pub.L. 100-360, § 411(b)(8)(A)(i), amended Pub.L. 100-203, § 4009(a)(1), to add subpars. (A) and (B), designate provision defining the term "responsible physician" as subpar. (C) and, in subpar. (C) as so designated, substitute "this paragraph" for "previous sentence" and redesignated former subpars. (A) and (B) as clss. (i) and (ii), respectively, and strike out provision that in addition to the other grounds for imposition of a civil money penalty under section 1320a-7a(a) of this title, a participating hospital that knowingly violates a requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject, under that section, to a civil money penalty of not more than $50,000 for each such violation.

Subsec. (d)(2). Pub.L. 100-203, § 4009(a)(1), as amended Pub.L. 100-485, § 608(d)(18)(E), added subpars. (A) and (B), designated provision defining term "responsible physician" as subpar. (C) and, in subpar. (C) as so designated, substituted "this paragraph" for "the previous sentence" and redesignated former subpars. (A) and (B) as clss. (i) and (ii), respectively, and struck out provision that in addition to the other grounds for imposition of a civil money penalty under section 1320a-7a(a) of this title, a participating hospital that knowingly violated a
requirement of this section and the responsible physician in the hospital with respect to such a violation were each subject, under that section, to a civil money penalty of not more than $50,000 for each such violation.

1986 Amendments. Subsec. (b)(2), (3). Pub.L. 99-509 struck out "legally responsible" following "individual (or as a group)."

Subsec. (e)(3). Pub.L. 99-514 struck out "and has, under the agreement, obligated itself to comply with the requirements of this section" after "section 1395cc of this title".

Effective and Applicability Provisions


1997 Acts. Amendment by section 4201 of Pub.L. 105-33 applicable to services furnished on or after October 1, 1997, see section 4201(d) of Pub.L. 105-33, set out as a note under section 1395f of this title.

1990 Acts. Amendment by section 4008(b)(1), (2) and (3)(A) of Pub.L. 101-508 applicable to actions occurring on or after the first day of the sixth month beginning after Nov. 5, 1990, see section 4008(b)(4) of Pub.L. 101-508, set out as a note under section 1395cc of this title.


Section 4207(a)(4), formerly 4027(a)(4), of Pub.L. 101-508, renumbered and amended Pub.L. 103-432, Title I, § 160(d)(4), (5)(B), Oct. 31, 1994, 108 Stat. 4444, provided that: "The amendments made by paragraphs (2) and (3) [amending subsec. (d)(2)(B) of this section] shall apply to actions occurring on or after the first day of the sixth month beginning after the date of the enactment of this Act [Nov. 5, 1990]."

1989 Acts. Section 6211(i) of Pub.L. 101-239 provided that: "The amendments made by this section [enacting subsecs. (c)(1)(A)(iii), (2)(A), and (g) to (i) of this section; amending section heading, subsecs. (a), (b), (c), (e)(1), (e)(2), (d)(2)(B), (C), and (e)(1) of this section; redesignating as subsec. (c)(2)(B) to (E) former subsec. (c)(2)(A) to (D) of this section; striking subsec. (e)(2) of this section; redesignating subsec. (e)(3) as subsec. (e)(2), and subsec. (e)(4) as subsec. (e)(3) and amending such subsection, and redesignating subsec. (e)(5), (6) as subsec. (e)(4), (5) of this section] shall take effect on the first day of the first month that begins more than 180 days after the date of the enactment of this Act [Dec. 19, 1989], without regard to whether regulations to carry out such amendments have been promulgated by such date."


Except as specifically provided in section 411 of Pub.L. 100-360, amendment by section 411 of Pub.L. 100-360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub.L. 100-203, effective as if included in the enactment of that provision of Pub.L. 100-203, see section 411(a)(2) of Pub.L. 100-360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

1987 Acts. Section 4009(a)(2), formerly 4009(a)(3) of Pub.L. 100-203, as renumbered by Pub.L. 100-360, Title IV, § 411(b)(8)(A), July 1, 1988, 102 Stat. 772, provided that: "The amendments made by this subsection [amending subsec. (d)(2), of this section] shall apply to actions occurring on or after the date of the enactment of this Act [Dec. 22, 1987]."

1986 Acts. Amendment by Pub.L. 99-514 effective, unless otherwise provided, as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub.L. 99-272, which was approved Apr. 7, 1986, see section 1895(e) of Pub.L. 99-514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Section 9121(c) of Pub.L. 99-272 provided that: "The amendments made by this section [enacting this section and section 1395cc(a)(1)(I) of this title] shall take effect on the first day of the first month that begins at least 90 days after the date of the enactment of this Act [Apr. 7, 1986]."
Prior Provisions


Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group

Pub.L. 108-173, Title IX, § 945, Dec. 8, 2003, 117 Stat. 2423, provided that:

"(a) Establishment.--The Secretary shall establish a Technical Advisory Group (in this section [this note] referred to as the "Advisory Group") to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) ([sic] probably means Emergency Medical Treatment and Active Labor Act, Aug. 14, 1935, ch. 531, Title XVIII, § 1867, as added Apr. 7, 1986, Pub.L. 99-272, Title IX, § 9121(b), 100 Stat. 164, and amended, which is classified to this section] and its implementation. In this section [this note], the term "EMTALA" refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd) [this section].

"(b) Membership.--The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which--

"(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

"(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics- gynecology, and psychiatry, with not more than one physician from any particular field;

"(3) 2 shall represent patients;

"(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

"(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients

"(c) General responsibilities.--The Advisory Group-

"(1) shall review EMTALA regulations;

"(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

"(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

"(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

"(d) Administrative matters.--

"(1) Chairperson.--The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

"(2) Meetings.--The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

"(e) Termination.--The Advisory Group shall terminate 30 months after the date of its first meeting.

"(f) Waiver of administrative limitation.--The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the
number of advisory committees that may be established (within the Department of Health and Human Services or otherwise)."

Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens.


"(a) Total amount available for allotment.--

"(1) In general.--Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $250,000,000 for each of fiscal years 2005 through 2008 for the purpose of making allotments under this section [of this note] for payments to eligible providers in States described in paragraph (1) or (2) of subsection (b) [of this note].

"(2) Availability.--Funds appropriated under paragraph (1) shall remain available until expended.

"(b) State allotments.--

"(1) Based on percentage of undocumented aliens.--

"(A) In general.--Out of the amount appropriated under subsection (a) [of this note] for a fiscal year, the Secretary shall use $167,000,000 of such amount to make allotments for such fiscal year in accordance with subparagraph (B).

"(B) Formula.--The amount of the allotment for payments to eligible providers in each State for a fiscal year shall be equal to the product of--

"(i) the total amount available for allotments under this paragraph for the fiscal year; and

"(ii) the percentage of undocumented aliens residing in the State as compared to the total number of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census.

"(2) Based on number of undocumented alien apprehension States.--

"(A) In general.--Out of the amount appropriated under subsection (a) [of this note] for a fiscal year, the Secretary shall use $83,000,000 of such amount to make allotments, in addition to amounts allotted under paragraph (1), for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

"(B) Determination of allotments.--The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall be equal to the product of--

"(i) the total amount available for allotments under this paragraph for the fiscal year; and

"(ii) the percentage of undocumented alien apprehensions in the State in that fiscal year as compared to the total of such apprehensions for all such States for the preceding fiscal year.

"(C) Data.--For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the apprehension rates for the 4-consecutive-quarter period ending before the beginning of the fiscal year for which information is available for undocumented aliens in such States, as reported by the Department of Homeland Security.

"(c) Use of funds.--

"(1) Authority to make payments.--From the allotments made for a State under subsection (b) [of this note] for a fiscal year, the Secretary shall pay the amount (subject to the total amount available from such allotments) determined under paragraph (2) directly to eligible providers located in the State for the provision of eligible services to aliens described in paragraph (5) to the extent that the eligible provider was not otherwise reimbursed (through insurance or otherwise) for such services during that fiscal year.

"(2) Determination of payment amounts.--

"(A) In general.--Subject to subparagraph (B), the payment amount determined under this paragraph shall be an amount determined by the Secretary that is equal to the lesser of--

"(i) the amount that the provider demonstrates was incurred for the provision of such services; or
"(ii) amounts determined under a methodology established by the Secretary for purposes of this subsection.

"(B) Pro-rata reduction.--If the amount of funds allotted to a State under subsection (b) [of this note] for a fiscal year is insufficient to ensure that each eligible provider in that State receives the amount of payment calculated under subparagraph (A), the Secretary shall reduce that amount of payment with respect to each eligible provider to ensure that the entire amount allotted to the State for that fiscal year is paid to such eligible providers.

"(3) Methodology.--In establishing a methodology under paragraph (2)(A)(ii), the Secretary--

"(A) may establish different methodologies for types of eligible providers;

"(B) may base payments for hospital services on estimated hospital charges, adjusted to estimated cost, through the application of hospital-specific cost-to-charge ratios;

"(C) Shall provide for the election by a hospital to receive either payments to the hospital for--

"(i) hospital and physician services; or

"(ii) hospital services and for a portion of the on-call payments made by the hospital to physicians; and

"(D) shall make quarterly payments under this section [this note] to eligible providers.

If a hospital makes the election under subparagraph (C)(i), the hospital shall pass on payments for services of a physician to the physician and may not charge any administrative or other fee with respect to such payments.

"(4) Limitation on use of funds.--Payments made to eligible providers in a State from allotments made under subsection (b) [of this note] for a fiscal year may only be used for costs incurred in providing eligible services to aliens described in paragraph (5).

"(5) Aliens described.--For purposes of paragraphs (1) and (2), aliens described in this paragraph are any of the following:

"(A) Undocumented aliens.

"(B) Aliens who have been paroled into the United States at a United States port of entry for the purpose of receiving eligible services.

"(C) Mexican citizens permitted to enter the United States for not more than 72 hours under the authority of a biometric machine readable border crossing identification card (also referred to as a 'laser visa') issued in accordance with the requirements of regulations prescribed under section 101(a)(6) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(6)).

"(d) Applications; advance payments.--

"(1) Deadline for establishment of application process.--

"(A) In general.--Not later than September 1, 2004, the Secretary shall establish a process under which eligible providers located in a State may request payments under subsection (c) [of this note].

"(B) Inclusion of measures to combat fraud and abuse.--The Secretary shall include in the process established under subparagraph (A) measures to ensure that inappropriate, excessive, or fraudulent payments are not made from the allotments determined under subsection (b) [of this note], including certification by the eligible provider of the veracity of the payment request.

"(2) Advance payment; retrospective adjustment.--The process established under paragraph (1) may provide for making payments under this section [this note] for each quarter of a fiscal year on the basis of advance estimates of expenditures submitted by applicants for such payments and such other investigation as the Secretary may find necessary, and for making reductions or increases in the payments as necessary to adjust for any overpayment or underpayment for prior quarters of such fiscal year.

"(e) Definitions.--In this section [this note]:

"(1) Eligible provider.--The term 'eligible provider' means a hospital, physician, or provider of ambulance services (including an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal
(2) Eligible services.--The term 'eligible services' means health care services required by the application of section 1867 of the Social Security Act (42 U.S.C. 1395dd) [this section], and related hospital inpatient and outpatient services and ambulance services (as defined by the Secretary).

(3) Hospital.--The term 'hospital' has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)), except that such term shall include a critical access hospital (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1)).

(4) Physician.--The term 'physician' has the meaning given that term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

(5) Indian tribe; tribal organization.--The terms 'Indian tribe' and 'tribal organization' have the meanings given in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(6) State.--The term 'State' means the 50 States and the District of Columbia.

Inspector General Study of Prohibition on Hospital Employment of Physicians

Section 4008(c) of Pub.L. 101-508 provided that:

(1) Study.--The Secretary of Health and Human Services (acting through the Inspector General of the Department of Health and Human Services) shall conduct a study of the effect of State laws prohibiting the employment of physicians by hospitals on the availability and accessibility of trauma and emergency care services, and shall include in such study an analysis of the effect of such laws on the ability of hospitals to meet the requirements of section 1867 of the Social Security Act [this section] relating to the examination and treatment of individuals with an emergency medical condition and women in labor.

(2) Report.--By not later than 1 year after the date of the enactment of this Act [Nov. 5, 1990], the Secretary shall submit a report to Congress on the study conducted under paragraph (1)."


Preventing "patient-dumping": the Supreme Court turns away the sixth circuit's interpretation of EMTALA Wendy W. Bera, 36 Hous. L. Rev. 615 (1999).


Tailoring EMTALA to better protect the indigent: The Supreme Court precludes one method of salvaging a statute gone awry. Michael J. Frank, 3 DePaul J. Health Care L. 195 (2000).


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Protecting your clients' interests under the new Medicaid law. Joel D. Muhlbaum, 4 Conn.Law. 3 (1993).

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Health 197, 258, 533, 658.

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Corpus Juris Secundum

CJS Municipal Corporations § 826.

Applicability in Particular Cases -- Federal Claims.

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113 ALR 5th 95, Validity, Construction, and Application of State Statutes Limiting or Barring Public Health Care to Indigent Aliens.

58 ALR 5th 613, Hospital Liability as to Diagnosis and Care of Patients in Emergency Room.

51 ALR 5th 301, Malpractice in Diagnosis or Treatment of Meningitis.

48 ALR 5th 575, Malpractice in Diagnosis and Treatment of Male Urinary Tract and Related Organs.


6 ALR 5th 490, Liability of Hospital, Physician, or Other Medical Personnel for Death or Injury to Mother or Child Caused by Improper Treatment During Labor.

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31 Am. Jur. Proof of Facts 2d 265, Rupture of Blood Vessel Due to Trauma.

1 Am. Jur. Proof of Facts 3d 691, Failure to Diagnose Impending Heart Attack.


62 Am. Jur. Trials 119, Establishing Hospital Liability Under the Emergency Medical Treatment and Active Labor Act for "Patient Dumping".

63 Am. Jur. Trials 1, Decisionmaking at the End of Life.

67 Am. Jur. Trials 271, Liability of Hospital or Other Emergency Room Service Provider for Injury to Patient or Visitor.


Am. Jur. 2d Hospitals and Asylums § 12, Financial Aid to Hospitals -- Duty to Provide Emergency Aid.

Am. Jur. 2d Hospitals and Asylums § 15, Patients; Admission -- Discharge.

Am. Jur. 2d Hospitals and Asylums § 27, Generally.


Forms

Federal Procedural Forms § 37:57, Scope of Division.

Federal Procedural Forms § 37:58, Right to Treatment.


Federal Procedural Forms § 37:61, Civil Penalties.

Federal Procedural Forms § 37:62, Allegations in Complaint-Action Under Emergency Medical Treatment and Active Labor Act--For Damages for Personal Injury and Declaratory and Injunctive Relief--Failure of Hospital to Provide Emergency Medical...

2B West's Federal Forms § 1766, Complaint Against Hospital Under Emergency Medical Treatment and Active Labor Act.

2B West's Federal Forms § 1766.5, Complaint Against Hospital Under Emergency Medical Treatment and Active Labor Act--Another Form.

27A West's Legal Forms § 17.31, General Considerations.

27A West's Legal Forms § 17.81, General Considerations.


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1. Constitutionality

Imposition of civil penalty on physician for violating provisions of Emergency Medical Treatment and Active Labor Act (EMTALA) did not effect unconstitutional public taking of his services without just compensation, since EMTALA did not effect taking; EMTALA imposed no responsibility directly on physicians, but rather unambiguously required hospitals to meet its requirements, and physician was free to negotiate with hospital regarding his responsibility to facilitate hospital's compliance with EMTALA.  Burditt v. U.S. Dept. of Health and Human Services, C.A.5 1991, 934 F.2d 1362.


2. Purpose

The reason Congress enacted Emergency Medical Treatment and Active Labor Act (EMTALA) in large part was because states generally had not made tort remedies available for the refusal to provide emergency care. Williams v. U.S., C.A.4 (N.C.) 2001, 242 F.3d 169. Health 658

Emergency Medical Treatment and Active Labor Act (EMTALA) was not intended to be used as federal malpractice statute, but instead was enacted to

Congress enacted Emergency Medical Treatment and Active Labor Act (EMTALA) to allay concern over increasing number of reports that, as health-care costs rose and third-party payments assumed increased importance, hospitals were refusing to accept or treat patients with emergency conditions if patient did not have medical insurance. Correa v. Hospital San Francisco, C.A.1 (Puerto Rico) 1995, 69 F.3d 1184, certiorari denied 116 S.Ct. 1423, 517 U.S. 1136, 134 L.Ed.2d 547.

Purpose of Emergency Medical Treatment and Active Labor Act (EMTALA) is to prevent hospitals from "dumping" patients who are unable to pay by either refusing to provide emergency medical treatment or by transferring patients before their emergency conditions are stabilized. Matter of Baby K, C.A.4 (Va.) 1994, 16 F.3d 590, certiorari denied 115 S.Ct. 91, 513 U.S. 825, 130 L.Ed.2d 42.

The purpose of Emergency Medical Treatment and Active Labor Act (EMTALA) is to bridge the gap not covered by state malpractice laws and to ensure that there be some screening procedure, and that it be administered even-handedly. Lopez Morales v. Hospital Hermanos Melendez, D.Puerto Rico 2003, 245 F.Supp.2d 374.

The purpose of the Emergency Medical Treatment and Active Labor Act (EMTALA) is to ensure that each patient is accorded the same level of treatment and to prohibit dumping of unstabilized patients. Scott v. Hutchinson Hosp., D.Kan.1997, 959 F.Supp. 1351.

In enacting the Emergency Medical Treatment and Active Labor Act (EMTALA), Congress, at a minimum, manifested an intent that all patients be treated fairly when they arrive in the emergency department of a participating hospital and that all patients who need some treatment will get a first response at minimum and will not simply be turned away. Dominguez-Perez v. Hospital Auxilio Mutuo, D.Puerto Rico 2003, 275 F.Supp.2d 135. Health 258

Congress' purpose in enacting Emergency Medical Treatment and Active Labor Act (EMTALA) was to prevent patient dumping--the practice of refusing to treat uninsured patients. Dollard v. Allen, D.Wyo.2003, 260 F.Supp.2d 1127. Health 197; Health 258

Emergency Medical Treatment and Active Labor Act (EMTALA) was not designed to function as a federal malpractice statute or to supplant state law medical malpractice suits. Dollard v. Allen, D.Wyo.2003, 260 F.Supp.2d 1127. Health 658

Purpose of the Emergency Medical Treatment and Active Labor Act (EMTALA), in principal part, was to require participating hospitals with emergency facilities to provide emergency care to all individuals who come there by determining whether an emergency condition exists and then stabilizing that condition. Bergwall v. MGH Health Services, Inc., D.Md.2002, 243 F.Supp.2d 364.

EMTALA is not intended to ensure each emergency room patient a correct diagnosis, but rather to ensure that each is accorded the same level of treatment regularly provided to patients in similar medical circumstances. Kilroy v. Star Valley Medical Center, D.Wyo.2002, 237 F.Supp.2d 1298.

Purpose of Emergency Medical Treatment and Active Labor Act (EMTALA) is to provide an adequate first response to a medical crisis for all patients, and send a clear signal to the hospital community that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress. Gardner v. Elmore Community Hosp., M.D.Ala.1999, 64 F.Supp.2d 1195. Health 258

Emergency Medical Treatment and Active Labor Act (EMTALA), or "Anti-Dumping Act," was enacted by Congress with clear and specific purpose of allaying concerns about the increasing number of reports that hospital emergency rooms were refusing to accept or treat patients with emergency conditions if the patient did not have medical insurance. Torres Nieves v. Hospital Metropolitano, D.Puerto Rico 1998, 998 F.Supp. 127.

Purposes of Emergency Medical Treatment and Active Labor Act (EMTALA) are to ensure that each patient is accorded same level of treatment and to prohibit dumping of unstabilized patients. Scott v. Hutchinson Hosp., D.Kan.1997, 959 F.Supp. 1351.

Congress enacted Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986 in response to...
 growing concern that hospitals were "dumping" patients unable to pay, by either refusing to provide emergency medical treatment or transferring patients before their emergency conditions were stabilized; for that reason, EMTALA imposes two primary requirements on participating hospitals that they provide appropriate screening to anyone presented for treatment to determine if emergency medical condition exists, and stabilize any such emergency condition before discharging or transferring patient. Gerber v. Northwest Hosp. Center, Inc., D.Md.1996, 943 F.Supp. 571.

Purpose of Emergency Medical Treatment Act of Labor Act (EMTALA) is to provide adequate first response to medical crisis for all patients and send clear signal to hospital community that all Americans, regardless of wealth or status, should know that hospital will provide what services it can when they are truly in physical distress. Vaughan Regional Medical Center v. Smith, M.D.Ala.1995, 916 F.Supp. 1142.

Emergency Medical Treatment and Active Labor Act (EMTALA) was designed to provide adequate first response to medical crisis for all patients, and was not intended to provide federal remedy for general medical malpractice redressable under state law; Congress intended to remedy deficiency under traditional state tort law which does not impose legal duty on hospital to provide access to, and treatment in, emergency room for those who are unable to afford it. Hussain v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc., E.D.Va.1996, 914 F.Supp. 1331.

Purpose of Emergency Medical Treatment and Active Labor Act (EMTALA) is to protect against dumping patients who do not have insurance and cannot afford to pay for emergency services. Vickers v. Nash General Hosp., Inc., E.D.N.C.1995, 875 F.Supp. 313, affirmed 78 F.3d 139.

Central problem sought to be addressed by Emergency Medical Treatment and Active Labor Act (EMTALA) is "patient dumping," which is denial of treatment due to inability to pay or lack of insurance. Tolton v. American Biodyne, Inc., N.D.Ohio 1993, 854 F.Supp. 505, affirmed 48 F.3d 937.

Purpose of Patient Anti-Dumping Act is to prevent emergency rooms from refusing care to individual because of his or her financial condition or lack of medical insurance; in other words, statute mandates that all patients be treated equally with respect to medical screening examination. Anadumaka By and Through Anadumaka v. Edgewater Operating Co., N.D.Ill.1993, 823 F.Supp. 507.

Congress did not exceed its constitutional spending powers when it enacted Comprehensive Omnibus Budget Reconciliation Act (COBRA) provision that prohibited patient dumping by hospitals that receive Medicare funds; purpose behind Medicare program and purpose behind COBRA were to permit access to health care for all Americans. Jones v. Wake County Hosp. System, Inc., E.D.N.C.1991, 786 F.Supp. 538.

3. Construction with other laws

Even if federal statutory duties were included in claims for which United States waived immunity in Federal Tort Claims Act (FTCA), United States would not be liable under FTCA based on Emergency Medical Treatment and Active Labor Act (EMTALA) if Indian hospital operated by United States refused emergency medical treatment to non-Indian patient, inasmuch as Indian Health Care Improvement Act did not mandate that Indian hospitals provide emergency services to non-Indians, and decision whether to provide such treatment was at hospital's discretion and thus was excepted from FTCA's waiver. Williams v. U.S., C.A.4 (N.C.) 2001, 242 F.3d 169. United States 78(9)

4. Law governing

Law of the place governing claim by non-Indian patient's estate that Indian hospital operated by United States wrongfully refused emergency medical treatment to patient, for purposes of Federal Tort Claims Act (FTCA) section vesting federal jurisdiction over FTCA claims where United States, if private person, would be liable to claimant in accordance with law of the place where act or omission occurred, was state law, and did not include federal law such as Emergency Medical Treatment and Active Labor Act (EMTALA) and Bivens principle that tort suit could be brought against United States based directly on Constitution. Williams v. U.S., C.A.4 (N.C.) 2001, 242 F.3d 169. United States 78(14)

Once Emergency Medical Treatment and Active Labor Act (EMTALA) has met purpose of ensuring that hospital undertakes stabilizing treatment of patient who arrives with emergency condition, patient's care becomes legal responsibility of hospital and treating physicians, and legal adequacy of that
care is then governed by state malpractice law. Bryan v. Rectors and Visitors of University of Virginia, C.A.4 (Va.) 1996, 95 F.3d 349.


Because a potential direct conflict exists between Utah's state law pre-litigation claim screening requirements for medical malpractice cases and the Emergency Medical Treatment and Liability Act's (EMTALA) statute of limitations, EMTALA preempts state law on this point; as a result, Utah state pre-litigation screening requirements are not incorporated into EMTALA and do not toll EMTALA's two-year limitations period. Merce v. Greenwood, D.Utah 2004, 348 F.Supp.2d 1271.

Limitation Of Actions 105(1); States 18.15


Hospital's liability under Emergency Medical Treatment and Active Labor Act (EMTALA) is not grounded upon tort concepts; EMTALA plaintiff's claim does not rest on any proof that hospital was negligent, but is predicated on hospital's violation of federal statute making hospital strictly liable for any personal harm that directly results from that violation. Griffith v. Mt. Carmel Medical Center, D.Kan.1994, 842 F.Supp. 1359.

Alabama statute requiring that medical malpractice claims be pled with detailed specification and factual description of each act and omission alleging liability of health care provider did not apply to claim against owner and operator of Alabama hospital under Emergency Medical Treatment and Active Labor Act (EMTALA); pleading necessary for state medical malpractice action, a state procedural requirement, was totally different from and irrelevant to cause of action based upon violation of federal statute. Holcomb v. Monahan, M.D.Ala.1992, 807 F.Supp. 1526.

Damages recoverable for medical malpractice under Emergency Medical Treatment and Active Labor Act were limited by Virginia statute imposing $1 million statutory cap on medical malpractice recoveries; Act's provision that plaintiffs can "obtain those damages available for personal injury under the law of the State in which the hospital is located" explicitly incorporated damage limit imposed by Virginia statute. Lee by Wetzel v. Alleghany Regional Hosp. Corp., W.D.Va.1991, 778 F.Supp. 900.


5. ---- Personal injuries, law governing


Kansas comparative fault law did not apply to hospital's liability under Emergency Medical Treatment and Active Labor Act (EMTALA), even though the only damages available to plaintiff under EMTALA were those available under state law; plaintiff was not required to prove that hospital acted negligently in order to recover under EMTALA, and fact that statute allowed recovery of damages available under state law did not transform liability portions of statute into negligence or tort-based statute. Griffith v. Mt. Carmel Medical Center, D.Kan.1994, 842 F.Supp. 1359.

Section of Emergency Medical Treatment and Active Labor Act providing that individual plaintiffs can "obtain those damages available for personal injury under the law of the State in which the hospital is located" did not apply only to state statutes governing all personal injury recoveries, inasmuch as there was apparently no state statute which generally limited all personal injury damages. Lee by Wetzel v. Alleghany Regional Hosp. Corp., W.D.Va.1991, 778 F.Supp. 900.

6. State regulation or control

Emergency Medical Treatment and Active Labor Act's (EMTALA) patient stabilization requirement ends when an emergency room patient is admitted for
inpatient care, absent evidence that inpatient admission was done to avoid EMTALA requirement; after patient is admitted for inpatient care, state tort law provides a remedy for negligent care. Bryant v. Adventist Health Systems/West, C.A.9 (Cal.) 2002, 289 F.3d 1162. Health 658

State sovereign immunity statute was in direct conflict with Emergency Medical Treatment and Active Labor Act (EMTALA) section permitting individual to seek damages for violation of EMTALA, which required hospitals to perform certain medical screening and stabilization procedures, and state statute was thus preempted by EMTALA pursuant to supremacy clause. Root v. New Liberty Hosp. Dist., C.A.8 (Mo.) 2000, 209 F.3d 1068, rehearing and rehearing en banc denied. Health 607; States 18.37

Virginia's limitation on liability of certain charitable and tax-exempt hospitals for "negligence or other tort" applied to disparate screening claim against such hospital under federal Emergency Medical Treatment and Active Labor Act (EMTALA), notwithstanding contention that action under EMTALA was neither negligence nor tort action; although arising under federal statutory requirements, claim was premised on hospital's alleged disparate provision of medical services. Power v. Arlington Hosp. Ass'n, C.A.4 (Va.) 1994, 42 F.3d 851.

Emergency Medical Treatment and Active Labor Act (EMTALA) preempts inconsistent provisions of state law authorizing physicians to refuse to give such care as they determine to be medically or ethically inappropriate. Matter of Baby K, C.A.4 (Va.) 1994, 16 F.3d 590, certiorari denied 115 S.Ct. 91, 513 U.S. 825, 130 L.Ed.2d 42.

Oregon's one-year notice requirement for wrongful death claims against public bodies was not preempted in action filed against county, as operator of county hospital, for violating the federal Emergency Medical Treatment and Active Labor Act (EMTALA), even though EMTALA has two-year statute of limitations; plaintiff may comply with both federal and state law by giving notice required under state statute within one year and filing lawsuit under Act within two years. Draper v. Chiapuzio, C.A.9 (Or.) 1993, 9 F.3d 1391.

Although scope of Maryland Malpractice Act's language broadly covers all claims against health care providers for medical injuries, Act applies only to traditional malpractice claims arising from breach by professional of duty to comply with relevant standard of care. Brooks v. Maryland General Hosp., Inc., C.A.4 (Md.) 1993, 996 F.2d 708.

Emergency Medical Treatment and Active Labor Act (EMTALA) was never intended to displace state law regarding medical malpractice or negligence; Congress deliberately left the establishment of malpractice liability to state law, limiting EMTALA's role to imposing on a hospital's emergency room the duty to screen all patients as any paying patient would be screened and to stabilize any emergency condition discovered. Bergwall v. MGH Health Services, Inc., D.Md.2002, 243 F.Supp.2d 364.


Congress did not unequivocally express an intent to abrogate Eleventh Amendment immunity for state owned and operated hospitals in the Emergency Medical Treatment and Active Labor Act (EMTALA), and thus, parent could not maintain suit in federal court against a state university's board of regents under the EMTALA for the suicide of her daughter in a state university hospital, absent a showing the state waived its immunity. Ward v. Presbyterian Healthcare Services, D.N.M.1999, 72 F.Supp.2d 1285. Federal Courts 265; Federal Courts 266.1

State statute requiring pre-litigation notice and screening of medical malpractice claims did not apply to action arising under Emergency Medical Treatment and Active Labor Act (EMTALA). Hewett v. Inland Hosp., D.Me.1999, 39 F.Supp.2d 84. Health 807

Plaintiff's state law claims against hospital, individual physicians, and personal company for lost chance of recovery or survival was not "same claim" as, and thus did not require dismissal of, her claim in federal court against hospital for violating Emergency Medical Treatment and Active Labor Act (EMTALA) by failing to provide appropriate medical screening or medical examination or treatment to stabilize condition of patient who died later that day;
in state court action, plaintiff alleged that defendants failed to meet relevant standard of care for health care providers under Missouri law, and in contrast, plaintiff alleged in federal court that hospital violated statutory requirements of EMTALA, which is not federal malpractice statute. Baucom v. DePaul Health Center, E.D.Mo.1996, 918 F.Supp. 288.

Emergency Medical Treatment Act of Labor Act (EMTALA), that governed duties of hospital when presented with patient seeking emergency medical care, did not preempt state statutory scheme governing licensing requirements for hospitals to provide care in state, and so state agency was not required to consider EMTALA in determining whether hospital met state requirements; causes of action provided by EMTALA seek relief against participating hospital violating EMTALA, not against state agency responsible for licensing hospitals. Vaughan Regional Medical Center v. Smith, M.D.Ala.1995, 916 F.Supp. 1142.

Stroke victim was not required to comply with Florida procedural requirements for medical malpractice actions in order to maintain action under Emergency Medical Treatment and Active Labor Act (EMTALA), in which he alleged that hospital violated EMTALA by discharging him without first stabilizing his condition; while EMTALA adopted state law damage limits on personal injury claims, it did not specifically incorporate limits on medical malpractice actions. Cooper v. Gulf Breeze Hosp., Inc., N.D.Fla.1993, 839 F.Supp. 1538.

There was direct conflict between Missouri doctrine of sovereign immunity and the Emergency Medical Treatment and Active Labor Act (EMTALA) to extent public hospital claimed to be immune from "patient dumping" claim and, therefore, doctrine of sovereign immunity was preempted by terms of EMTALA. Helton v. Phelps County Regional Medical Center, E.D.Mo.1993, 817 F.Supp. 789.

Operation of Virginia law limiting liability of certain charitable hospitals for negligence or other torts was barred by preemption doctrine in federal patient dumping action brought by plaintiff under Emergency Medical Treatment and Active Labor Act (EMTALA); Virginia statute's operation conflicted directly with intent, scope, and application of EMTALA. Power v. Arlington Hosp., E.D.Va.1992, 800 F.Supp. 1384, affirmed in part, reversed in part 42 F.3d 851.

7. Patient dumping

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a limited anti-dumping statute, not a federal malpractice statute. Dominguez-Perez v. Hospital Auxilio Mutuo, D.Puerto Rico 2003, 275 F.Supp.2d 135. Health 658

"Patient dumping" refers to practice of transferring or refusing to treat patient for economic reasons, but plaintiff need not show hospital's motive was to dump patient in order to recover under Emergency Medical Treatment and Active Labor Act (EMTALA) for improper screening, treatment, discharge, or transfer. Scott v. Hutchinson Hosp., D.Kan.1997, 959 F.Supp. 1351.

8. Malpractice distinguished

A hospital does not violate Emergency Medical Treatment and Active Labor Act (EMTALA), requiring a hospital to stabilize patient who presents with emergency medical condition, regardless of insurance or ability to pay, if hospital fails to detect or misdiagnoses an emergency condition; rather, an individual who receives substandard medical care may pursue medical malpractice remedies under state law. Bryant v. Adventist Health Systems/West, C.A.9 (Cal.) 2002, 289 F.3d 1162. Health 658

Treating physician's failure to appreciate extent of patient's injury or illness, as well as subsequent failure to order additional diagnostic procedure, may constitute negligence or malpractice, but cannot support Emergency Medical Treatment and Active Labor Act (EMTALA) claim for inappropriate screening. Marshall on Behalf of Marshall v. East Carroll Parish Hosp. Service Dist., C.A.5 (La.) 1998, 134 F.3d 319.

Emergency Medical Treatment and Active Labor Act (EMTALA) is limited "anti-dumping" statute, not federal malpractice statute, with core purpose to deal with problem of patients being turned away from emergency rooms for nonmedical reasons. Bryan v. Rectors and Visitors of University of Virginia, C.A.4 (Va.) 1996, 95 F.3d 349.

Claim of misdiagnosis asserted by widow of patient who died of heart attack after he was discharged from emergency room of defendant hospital was not cognizable under Emergency Medical Treatment and Active Labor Act; Act does not create sweeping federal cause of action with respect to what are traditional state-based claims of negligence or malpractice. *Gatewood v. Washington Healthcare Corp.*, C.A.D.C.1991, 933 F.2d 1037, 290 U.S.App.D.C. 31.

Questions regarding whether a physician or other hospital personnel failed properly to diagnose or treat a patient's condition are best resolved under existing and developing state negligence and medical malpractice theories of recovery, rather than under the Emergency Medical Treatment and Active Labor Act (EMTALA). *Bergwall v. MGH Health Services, Inc.*, D.Md.2002, 243 F.Supp.2d 364.


Emergency Medical Treatment and Active Labor Act (EMTALA) was not designed to function as a federal malpractice statute or to supplant state law medical malpractice suits. *Dollard v. Allen*, D.Wyo.2003, 260 F.Supp.2d 1127. Health 658


State malpractice claims, including those arising out of misdiagnosis by health care provider, are not actionable under Emergency Medical Treatment and Active Labor Act (EMTALA); EMTALA was intended by Congress to provide limited federal remedy to plaintiffs who sought and were denied aid in emergency rooms, and was not intended to turn federal courts into fora for state malpractice claims. *Hart v. Mazur*, D.R.I.1995, 903 F.Supp. 277.

Emergency Medical Treatment and Active Labor Act (EMTALA) was not designed as federal malpractice statute, but was enacted because of Congress' concern that hospitals were abandoning longstanding practice of providing emergency care to all due to increasing pressures to lower costs and maximize efficiency, and because traditional state tort law did not require hospitals to provide such care. *Reynolds v. Mercy Hosp.*, W.D.N.Y.1994, 861 F.Supp. 214.

Emergency Medical Treatment and Active Labor Act does not incorporate a malpractice or negligence standard available under state law, and a negligent misdiagnosis does not give rise to claim under the Act. *Hutchinson v. Greater Southeast Community Hosp.*, D.D.C.1992, 793 F.Supp. 6, affirmed.

Claim for improper emergency room diagnosis and treatment was traditional medical malpractice claim that was not cognizable under the Emergency Medical Treatment and Active Labor Act, where it was uncontroversial that patient was never denied treatment or discharge from medical center due to lack of insurance; case was not one involving patient dumping, sought to be addressed by Act. *Stewart v. Myrick*, D.Kan.1990, 731 F.Supp. 433.

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Emergency Medical Treatment and Active Labor Act (EMTALA) was not designed as federal malpractice statute, but was enacted because of Congress' concern that hospitals were abandoning longstanding practice of providing emergency care to all due to increasing pressures to lower costs and maximize efficiency, and because traditional state tort law did not require hospitals to provide such care. *Reynolds v. Mercy Hosp.*, W.D.N.Y.1994, 861 F.Supp. 214.

Emergency Medical Treatment and Active Labor Act does not incorporate a malpractice or negligence standard available under state law, and a negligent misdiagnosis does not give rise to claim under the Act. *Hutchinson v. Greater Southeast Community Hosp.*, D.D.C.1992, 793 F.Supp. 6, affirmed.

Claim for improper emergency room diagnosis and treatment was traditional medical malpractice claim that was not cognizable under the Emergency Medical Treatment and Active Labor Act, where it was uncontroversial that patient was never denied treatment or discharge from medical center due to lack of insurance; case was not one involving patient dumping, sought to be addressed by Act. *Stewart v. Myrick*, D.Kan.1990, 731 F.Supp. 433.

State malpractice claims, including those arising out of misdiagnosis by health care provider, are not actionable under Emergency Medical Treatment and Active Labor Act (EMTALA); EMTALA was intended by Congress to provide limited federal remedy to plaintiffs who sought and were denied aid in emergency rooms, and was not intended to turn federal courts into fora for state malpractice claims. *Hart v. Mazur*, D.R.I.1995, 903 F.Supp. 277.

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 9. Participating hospital

Puerto Rico centros de diagnostico y tratamiento (CDTs), or outpatient health facilities, which have emergency rooms that render emergency medical services on 24-hour basis fall within auspices of Emergency Medical Treatment and Active Labor Act (EMTALA), which was intended, in spirit, to cover types of services provided by such CDTs. *Rodriguez v. American Intern. Ins. Co. of Puerto Rico*, D.Puerto Rico 2003, 263 F.Supp.2d 297. Health 658

Municipality's diagnostic and treatment center did not qualify as a "participating hospital" under the Emergency Medical Treatment and Active Labor Act (EMTALA) because it was not a hospital and, as such, did not have an emergency care department; the center did not provide services to inpatients or provide 24-hour nursing service, and Puerto Rico law clearly distinguished between hospitals and diagnostic and treatment centers. *Feliciano Rivera v.*

Corporate provider of medical professional services at hospital was not a "participating hospital" covered by Emergency Medical Treatment and Active Labor Act (EMTALA); corporation had not entered into a Medicare provider agreement with the federal government or received Medicare payments. Medero Diaz v. Grupo De Empresas De Salud, D.Puerto Rico 2000, 112 F.Supp.2d 222. Health 258

10. Health care plan providers

Puerto Rico outpatient diagnostic and treatment center known as centro de diagnosticoy tratamiento (CDT) was not a "hospital" within definition incorporated into Emergency Medical Treatment and Active Labor Act (EMTALA), and thus was outside EMTALA's coverage, even though Medicare-eligible center had 24-hour emergency room; center treated only ambulatory patients, not inpatients, territorial law did not license CDTs as hospitals, and center's emergency room was independent of any hospital. Rodriguez v. American Intern. Ins. Co. of Puerto Rico, 2005, 402 F.3d 45. Health 658

Federal "antidumping" provisions prohibiting discharge of emergency room patients who lack insurance applied only to hospital's duty to treat patients and not to health maintenance organization's (HMO) duty to provide plan participant with care. Dearmas v. Av-Med, Inc., S.D.Fla.1993, 814 F.Supp. 1103.

11. Patients within section

"Treat or transfer" protection of Emergency Medical Treatment and Active Labor Act (EMTALA) extends to patient whose condition would seriously impair patient's health absent immediate medical care and those who will, within reasonable medical probability, deliver babies before safe transfer can be effected. Burditt v. U.S. Dept. of Health and Human Services, C.A.5 1991, 934 F.2d 1362.

12. Hospital duty

The Emergency Treatment and Active Labor Act (EMTALA) imposes upon a hospital's emergency services the duty to initially screen patients to ascertain whether an emergency medical condition exists and if so, to provide the necessary medical examination and treatment as well as to stabilize the patient prior to his discharge or transfer. Monrouzeau v. Asociacion del Maestro, D.Puerto Rico 2005, 354 F.Supp.2d 115. Health 258

Provisions of Emergency Medical Treatment and Active Labor Act (EMTALA), or Anti-Dumping Act, are to be interpreted conjunctively to impose two principal obligations on hospitals: (1) act requires that when individual seeks treatment at hospital emergency room, hospital provide for appropriate medical screening examination to determine whether "emergency medical condition" exists; and (2) if screening examination reveals presence of emergency medical condition, hospital ordinarily must stabilize medical condition before transferring or discharging patient. Lopez-Soto v. Hawayek, D.Puerto Rico 1997, 988 F.Supp. 41, supplemented 20 F.Supp.2d 279, reversed 175 F.3d 170.

Emergency Medical Treatment and Active Labor Act (EMTALA) imposes two requirements on any hospital which participates in Medicare program: hospital must conduct appropriate medical screening to persons visiting hospital's emergency room, and hospital generally may not transfer out of hospital patient whose medical condition has not been stabilized. Brewer By and Through Brewer v. Miami County Hosp., D.Kan.1994, 862 F.Supp. 813.

13. Physician duty

Surgeon was not required, under Emergency Medical Treatment and Active Labor Act (EMTALA), to force anesthesiologist to administer anesthesia to brain-injured accident victims, so as to permit surgeon to "stabilize" victims prior to their transfer to hospital equipped to deal with their head injuries by operating to stop their internal bleeding, after anesthesiologist had made his position clear that he would not provide anesthesia because it might kill victims; nothing in EMTALA demanded such a confrontation between surgeon and anesthesiologist. Cherukuri v. Shalala, C.A.6 1999, 175 F.3d 446. Health 197

14. Screening--Generally

"Appropriate medical screening examination" under Emergency Medical Treatment and Active Labor Act (EMTALA) is not judged by its proficiency in accurately diagnosing patient's illness, but rather by whether it was performed equitably in comparison to other patients with similar symptoms. Marshall on
EMTALA is implicated only when individuals who are perceived to have the same medical condition receive disparate treatment, and is not implicated whenever individuals who turn out in fact to have had the same condition receive disparate treatment; as a result, when an exercise in medical judgment produces a given diagnosis, the decision to prescribe a treatment responding to the diagnosis cannot form basis of an EMTALA claim of inappropriate screening. \textit{Summers v. Baptist Medical Center Arkadelphia, C.A.8 (Ark.) 1996, 91 F.3d 1132}.

Emergency Medical Treatment and Active Labor Act (EMTALA) is implicated only when individuals who are perceived to have same medical condition receive disparate treatment, and is not implicated whenever individuals who turn out in fact to have had same condition receive disparate treatment, as EMTALA would otherwise become indistinguishable from state malpractice law; accordingly, when exercise in medical judgment produces given diagnosis, decision to prescribe treatment responding to diagnosis cannot form basis of EMTALA claim of inappropriate screening. \textit{Vickers v. Nash General Hosp., Inc., C.A.4 (N.C.) 1996, 78 F.3d 139}.

In patient's action against hospital alleging violation of Emergency Medical Treatment and Active Labor Act (EMTALA), hospital was entitled to summary judgment where patient failed to show hospital treated patient differently from other patients; hospital was not required to disprove patient's claim that hospital failed to provide patient an appropriate medical screening by showing all patients were treated the same. \textit{Williams v. Birkeness, C.A.8 (Mo.) 1994, 34 F.3d 695}, rehearing denied.

If hospital applies same screening procedures to indigent patients that it applies to paying patients, hospital does not violate section of Emergency Medical Treatment and Active Labor Act (EMTALA) that requires hospitals to provide persons requiring emergency medical treatment with "appropriate medical screening examination"; "appropriateness" of screening is not determined by its adequacy in identifying patient's illness. \textit{Holcomb v. Monahan, C.A.11 (Ala.) 1994, 30 F.3d 116}.

Transferee hospital had no duty to provide "appropriate medical screening" of patient who had been transferred from another hospital's emergency department; patient had not presented herself for treatment at transferee hospital. \textit{Baber v. Hospital Corp. of America, C.A.4 (W.Va.) 1992, 977 F.2d 872}.

Hospital's alleged failure to diagnose a patient in an emergency facility accurately with an evolving acute myocardial infarction could not form the basis of a claim under the Emergency Medical Treatment and Active Labor Act (EMTALA); the critical element of the EMTALA cause of action was not the adequacy of the screening examination, but whether the examination that was performed deviated from the hospital's evaluation procedures that would have been performed on any patient in a similar condition. \textit{Bergwall v. MGH Health Services, Inc., D.Md.2002, 243 F.Supp.2d 364}.

Hospital's duty under Emergency Medical Treatment and Active Labor Act (EMTALA) to stabilize emergency room patient is activated only if hospital uncovers emergency medical condition, and applies only in context of patients who are discharged or transferred to another hospital. \textit{State of Giomard Rivera v. Doctor Susoni, Inc., D.Puerto Rico 2003, 288 F.Supp.2d 161}, reconsideration denied 323 F.Supp.2d 262, Health 258.

If a patient received "appropriate medical screening" equal to the screening offered to any paying patients and the individual is "stabilized" before transfer or discharge under the same parameters as a paying patient, no cause of action can be brought under the Emergency Medical Treatment and Active Labor Act (EMTALA). \textit{Heirs of Medero v. Susoni, D.Puerto Rico 2003, 281 F.Supp.2d 352}, vacated in part 2004 WL 2756854. Health 658.

Under the Emergency Medical Treatment and Active Labor Act (EMTALA) the issue is whether the procedures followed in the emergency room, even if they resulted in a misdiagnosis, were reasonably calculated to identify the patient's critical medical condition. \textit{Domínguez-Perez v. Hospital Auxilio Mutuo, D.Puerto Rico 2003, 275 F.Supp.2d 135}.
There is both a substantive and a procedural component to an appropriate medical screening under the Emergency Medical Treatment and Active Labor Act (EMTALA): a hospital fulfills its statutory duty to screen patients in its emergency room if it provides for a screening examination reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients and provides that level of screening uniformly to all those who present substantially similar complaints. Marrero v. Hospital Hermanos Melendez, Inc., D. Puerto Rico 2003, 253 F.Supp.2d 179.

Hospital fulfills its duty under Emergency Medical Treatment and Active Labor Act (EMTALA) to screen patients in its emergency room if it provides for a screening examination reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients and provides that level of screening uniformly to all those who present substantially similar complaints; essence of requirement is that there be some screening procedure, and that it be administered even-handedly, so that a refusal to follow regular screening procedures in a particular instance violates EMTALA, but faulty screening, in a particular case, does not contravene EMTALA. Gardner v. Elmore Community Hosp., M.D. Ala. 1999, 64 F.Supp.2d 1195.


Term "appropriate medical screening examination," as used in Emergency Medical Treatment and Active Labor Act (EMTALA), is interpreted to require hospitals to apply uniform screening procedures to all individuals coming to emergency room to determine whether emergency medical condition exists; essentially, screening provision aims at disparate treatment. Gerber v. Northwest Hosp. Center, Inc., D. Md. 1996, 943 F.Supp. 571.


Hospital fulfills its duty under Emergency Medical Treatment and Active Labor Act (EMTALA) to provide appropriate medical screening for patients in its emergency room if it provides for a screening examination reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients, and provides that level of screening uniformly to all those who present substantially similar complaints.

Emergency Medical Treatment and Active Labor Act (EMTALA) requires "appropriate" screening examinations, and even if that term is not interpreted to apply ordinary standards of care, it could well, in appropriate case, be held to proscribe even uniform screening examinations that are so substandard as to amount to no screening at all. Fisher v. Fisher v. New York Health and Hospitals Corp., E.D. N.Y. 1998, 989 F.Supp. 444.


"Appropriate," for purposes of requirement of Federal Emergency Medical Treatment and Active Labor Act that hospital provide appropriate medical screening examination, should not be defined solely in terms of plaintiff's treatment as compared with treatment provided similarly situated patient; although screening standard creates subjective test as to whether hospital treated plaintiff according to its own standards, court should not ignore evidence of accepted medical practice from which subjective standards can be inferred. Ruiz v. Kepler, D. N.M. 1993, 832 F.Supp. 1444.

15. ---- Particular screenings

Hospital did not violate the patient stabilization provision of Emergency Medical Treatment and Active Labor Act (EMTALA) by discharging patient with lung abscess and pneumonia from emergency room, even though lung abscess was emergency medical condition requiring stabilization and emergency physician ordered and reviewed lung x-ray while patient was in emergency room, where physician did not detect lung abscess before he discharged patient, and physician determined that pneumonia was stabilized after injecting patient with antibiotic. Bryant v. Adventist Health Systems/West, C.A. 9 (Cal.) 2002, 289 F.3d 1162.
psychiatrists, psychologists, or any other mental health professionals on staff, did not have duty under Emergency Medical Treatment and Active Labor Act (EMTALA) to provide a mental health screening for emergency room patient who had reported suicidal ideations, and thus did not violate EMTALA when it called in a crisis worker from county medical health department, pursuant to its written policy, to screen patient; hospital was only required under EMTALA to provide a screening examination that was within its capabilities, which did not include mental health examinations. Baker v. Adventist Health, Inc., C.A.9 (Cal.) 2001, 260 F.3d 987. Health ©258

Hospital did not disparately apply its screening policy for handling patients presenting mental health emergencies, which called for it to bring in crisis worker from county medical health department, and thus did not violate Emergency Medical Treatment and Active Labor Act (EMTALA), when it discharged patient who did not present a medical emergency, but had related that he had experienced suicidal ideations, and called county health department; written notation on discharge sheet, which directed patient to consult with health department, indicated that policy had been followed. Baker v. Adventist Health, Inc., C.A.9 (Cal.) 2001, 260 F.3d 987. Health ©258

Hospital satisfied its screening obligations under the Emergency Medical Treatment and Active Labor Act (EMTALA), though it failed to determine that patient was suffering from drug toxicity and not only a psychiatric condition; hospital's doctors and nurses performed screenings according to hospital's guidelines, patient was examined by a doctor during each of his visits to the hospital's emergency room, the physicians performed several physical examinations and ordered multiple laboratory tests, patient's survivors' own expert witnesses testified that they had no reasons to believe that patient was treated differently than other patients presenting similar symptoms, and there was no evidence that the examinations were not designed to identify acute and severe symptoms. Jackson v. East Bay Hosp., C.A.9 (Cal.) 2001, 246 F.3d 1248. Health ©258

Emergency room patient's physician's failure to perform ventilation perfusion scan (VQ scan) on patient did not violate hospital's duty under Emergency Medical Treatment and Active Labor Act (EMTALA) to perform initial screening examination, where physician diagnosed patient as having pneumonia and possible sepsis or pulmonary embolism, and hospital eventually admitted patient to intensive care unit. Harry v. Marchant, C.A.11 (Fla.) 2001, 237 F.3d 1315, rehearing granted, opinion vacated 259 F.3d 1310, opinion reinstated in part on rehearing 291 F.3d 767. Health ©258

Hospital had no duty, under Emergency Medical Treatment and Active Labor Act (EMTALA), to screen emergency patient for emergency medical conditions after patient had received initial screening and treatment for traumatic injuries to his lower extremities suffered in automobile accident, and thus was not liable under EMTALA for failing to screen patient for deep vein thrombosis, which may have developed after patient was at hospital; purpose of EMTALA, to ensure that emergency patients receive adequate first response to their medical crises, was satisfied once patient received treatment for his symptomatic injuries, and any failures of diagnosis or treatment had to be addressed under state medical malpractice laws. Reynolds v. MaineGeneral Health, C.A.1 (Me.) 2000, 218 F.3d 78. Health ©658

Emergency room surgeon did not violate Emergency Medical Treatment and Active Labor Act (EMTALA) when he transferred two brain-injured accident victims without first operating to stop victims' internal bleeding; under flexible standard for 'stabilise', abdominal surgery to stop victims' internal bleeding was not fixed requirement, surgeon was prevented from operating by anesthesiologist's refusal to administer anesthesia due to victims' head injuries, and experts testified that surgeon had no viable choice under the circumstances except to transfer victims to hospital equipped to handle their head injuries. Cherukuri v. Shalala, C.A.6 1999, 175 F.3d 446. Health ©197

Emergency room patient did not receive "disparate treatment" when hospital failed to take chest x-ray which would have revealed broken sternum and rib, and thus could not recover for inappropriate medical screening under EMTALA; though hospital would normally give x-ray to patient complaining of snapping noises in chest and patient allegedly made such complaints, lack of x-ray resulted from hospital's inadvertent failure to perceive patient's chest pain, and patient was treated no differently from any other patient not perceived to have such pain. Summers v. Baptist Medical Center Arkadelphia, C.A.8 (Ark.) 1996, 91 F.3d 1132.

Complaint failed to allege that patient who went to hospital emergency room with severe scalp laceration
was treated disparately from other patients with same symptoms and was insufficient to state claim of inappropriate screening under Emergency Medical Treatment and Active Labor Act (EMTALA), even though administrator of patient's estate contended that patient had received only staple sutures but not testing for intracranial injury, as others with same condition received; patient received initial screening examination and diagnosis, and any question as to accuracy of diagnosis was question for state malpractice law and not EMTALA.  


Finding that patient who complained of chest pains was denied appropriate screening examination by hospital, allowing recovery by patient's survivors under Emergency Medical Treatment and Active Labor Act (EMTALA), was supported by evidence that hospital's internal procedures required emergency room personnel to promptly take vital signs of all patients, make written records, and refer critical cases to physician, by testimony of patient's son that patient did not receive treatment during over two hours at hospital, and by hospital's failure to produce written record of visit.  


Alleged failure by nurses to take complete medical history when patient sought emergency care and to ask patient for complete list of medications that he was taking did not amount to such deviations from hospital's standard emergency room screening procedures as to amount to failure to perform appropriate medical screening as required under Emergency Medical Treatment and Active Labor Act (EMTALA); although hospital policy stated that patient's history should include preexisting conditions and medications and allergies, and although nurses did not ask specific questions about such items, they did receive information on each item.  


Hospital personnel's actions in taking emergency room patient's vital signs were sufficient to meet screening requirement under Emergency Medical Treatment and Active Labor Act (EMTALA), even though vital signs were not taken every 15 minutes, as stated on standard protocol, when nurse's notes established substantial compliance through checking of patient's vital signs approximately every 20 to 30 minutes.  


That automobile accident victim almost continuously received treatment after he arrived at hospital until he was transported to different hospital via air ambulance was prima facie showing that hospital satisfied screening requirement of Emergency Medical Treatment and Active Labor Act (EMTALA).  


Treatment of patient upon arrival in hospital emergency department, following patient's involvement in a serious automobile accident, fulfilled hospital's duty to adequately screen and stabilize patient, as required for claims brought by survivors of patient under the Emergency Medical Treatment and Active Labor Act (EMTALA); the medical record indicated that the hospital's staff immediately attended to patient upon his arrival at the hospital and tended to him consistently thereafter, and subsequent treatment consisted of tests that tried to elicit a diagnosis and adequate treatment.  


Hospital did not violate its duty under Emergency Medical Treatment and Active Labor Act (EMTALA) to properly screen patient at its emergency room, where emergency room physician triaged patient and accurately determined that he had emergency medical condition.  


A hospital fulfills its statutory duty under the Emergency Medical Treatment and Active Labor Act (EMTALA) to screen patients in its emergency room if it provides for a screening examination reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients and provides that level of screening uniformly to all those who present substantially similar complaints; the essence of this requirement is that there be some screening procedure, and that it be administered evenhandedly.  


Absent allegations as to any disparate treatment patient received when he was treated at hospital emergency room, hospital could not be held liable under the Emergency Medical Treatment and Active Labor Act (EMTALA) for failure to properly screen
as result of patient's death which occurred several days after his release from hospital, where some screening was conducted.  *Heirs of Medero v. Susoni, D.Puerto Rico 2003*, 281 F.Supp.2d 352, vacated in part 2004 WL 2756854.  Health 658

Hospital did not violate substantive screening requirement of Emergency Medical Treatment and Active Labor Act (EMTALA) with respect to patient who suffered cerebral infarct after his release, where hospital triaged patient upon his arrival following its guidelines for doing so, had his vital signs repeatedly checked, had him physically examined by doctor, had laboratory tests ordered and done, had all his vital systems reviewed by nurse, administered medication, and released him after six-hour stay and after he said he was feeling better.  *Dominguez-Perez v. Hospital Auxilio Mutuo, D.Puerto Rico 2003*, 275 F.Supp.2d 135.  Health 658

Hospital could not be held liable for deficient medical screening under Emergency Medical Treatment and Active Labor Act (EMTALA), based on an emergency room doctor's alleged delay in consulting with a pediatrician or pediatric surgeon, and failure to order x-rays, with regard to eight-month-old patient who came to emergency room based on vomiting and rectal bleeding; decision to utilize specialist was not mandated by hospital's screening protocol, hospital's interdepartmental policy did not impart duty on doctor to order x-rays, with regard to eight-month-old patient who came to emergency room following its guidelines for doing so, had his vital signs repeatedly checked, had him physically examined by doctor, had laboratory tests ordered and done, had all his vital systems reviewed by nurse, administered medication, and released him after six-hour stay and after he said he was feeling better.  *Dominguez-Perez v. Hospital Auxilio Mutuo, D.Puerto Rico 2003*, 275 F.Supp.2d 135.  Health 658


Hospital, which apparently accepted that injured hemophiliac who went to emergency room had an emergency, was required by Emergency Medical Treatment and Active Labor Act (EMTALA) to stabilize him before sending him home.  *Fuentes Ortiz v. Mennonite General Hospital, D.Puerto Rico 2000*, 106 F.Supp.2d 327.  Health 258

Hospital's screening of emergency room patient who had suffered syncopal episode did not violate Emergency Medical Treatment and Active Labor Act (EMTALA), even though hospital failed to take patient's cardiac risk factor history or to properly observe results of cardiac monitoring, and treating physicians failed to take additional history and do her own neurological examination when she took over patient's care after emergency room screening, where hospital personnel followed standard procedure for screening patient who presented himself or herself at emergency room with syncope.  *Feighery v. York Hosp., D.Me.1999*, 59 F.Supp.2d 96.  Health 258

Uninsured patient who was brought to private hospital's emergency room, complaining of abdominal pains, vomiting, and nausea, and who was diagnosed with acute appendicitis before being transferred to public hospital, received adequate medical screening at private hospital, as required under Emergency Medical Treatment and Active Labor Act (EMTALA); patient was subjected to battery of tests to identify source of symptoms and received medication and treatment to alleviate her pain, and nothing indicated that she received treatment different from that any paying patient would receive.  *Torres Nieves v. Hospital Metropolitano, D.Puerto Rico 1998*, 998 F.Supp. 127.
If patients who are perceived to have viral illnesses are screened similarly by hospital, Emergency Medical Treatment and Active Labor Act (EMTALA) has not been violated; that is true even if hospital's perception of particular patient is based on misdiagnosis. Fisher by Fisher v. New York Health and Hospitals Corp., E.D.N.Y.1998, 989 F.Supp. 444.

After hospital transferred emergency room patient to intensive care unit and began treating her condition, it met its responsibilities under Emergency Medical Treatment and Active Labor Act (EMTALA), and when doctor determined later the same day that hospital's facilities were inadequate and that patient should be transferred to another facility, EMTALA no longer applied. Scott v. Hutchinson Hosp., D.Kan.1997, 959 F.Supp. 1351.

Hospital's failure to initially discover emergency room patient's cardiac condition and internal bleeding condition could not amount to improper screening under Emergency Medical Treatment and Active Labor Act (EMTALA) in absence of evidence that hospital failed to follow its own standard screening procedure. Scott v. Hutchinson Hosp., D.Kan.1997, 959 F.Supp. 1351.

Patient who had sought treatment for physical condition in emergency room and who attempted suicide shortly after her discharge did not show that hospital had failed to stabilize her medical condition, and thus could not recover under Emergency Medical Treatment and Active Labor Act (EMTALA) based on alleged failure to treat her psychiatric condition; patient stated in her complaint that treating physician had diagnosed her as suffering from irritable bowel, esophageal reflux, hernia, and intestinal bleeding, and had prescribed various medications and course of treatment to stabilize condition. Fisher by Fisher v. New York Health and Hospitals Corp., E.D.N.Y.1998, 989 F.Supp. 444.

In action by patient, who entered emergency room with fractured skull, against hospital under Federal Emergency Medical Treatment and Active Labor Act, there were issues of fact, precluding summary judgment, as to whether hospital's screening procedure for head trauma patients was within capability of its emergency department; nurse did not note that she checked patient's level of consciousness using coma scale, no notation as to patient's pupil status was made, and patient's vital signs were recorded only once during his two-hour stay at hospital. Ruiz v. Kepler, D.N.M.1993, 832 F.Supp. 1444.

Even assuming that physician thought that patient lacked adequate insurance coverage and was unable to pay for hospital admission or observation, patient did not establish that physician conducted initial screening examination differently than he would have provided any other paying patient so as to establish that hospital breached its federal duty under Emergency Medical Treatment and Active Labor Act (EMTALA) to provide appropriate medical screening examination; failure to diagnose popliteal artery injury was not attributable to insurance motive, although it may have been attributable to malpractice, and there was no evidence that physician would have screened any other patient differently, but for the malpractice. Hines v. Adair County Public Hosp. Dist. Corp., W.D.Ky.1993, 827 F.Supp. 426.

Hospital's screening of child brought to emergency room after he choked on peanut was adequate under Patient Anti-Dumping Act, even though child underwent surgery at different hospital on following morning to remove peanut fragments from his respiratory system; evidence demonstrated that standard practice at triage and registration were performed in hospital's emergency room and, although mother disagreed with nurse' determination that child had nonemergency condition, that argument was one of misdiagnosis and was one that was not addressed by statute. Anadumaka By and Through Anadumaka v. Edgewater Operating Co., N.D.Ill.1993, 823 F.Supp. 507.

Hospital did not violate Emergency Medical Treatment and Active Labor Act's (EMTALA) screening provision with respect to patient who suffered burns and subsequently died from respiratory difficulties; plaintiffs could not dispute that screening examination performed on patient was in accordance with hospital's standard screening procedure used to detect emergency medical conditions, and whether physician may have failed to correctly ascertain patient's respiratory condition was not focus on question of proper screening. Smith v. Janes, S.D.Miss.1995, 895 F.Supp. 875.
been subjected to tests before determining that he was not suffering from medical emergency, and there was no indication that patient's condition was worsening at time of discharge. Petrovics v. Prince William Hosp. Corp., E.D.Va.1991, 764 F.Supp. 415.

16. **** Standard procedures

Mere de minimis variations from hospital's standard procedures do not amount to violation of hospital policy and thus violation of Emergency Medical Treatment and Active Labor Act's (EMTALA's) requirement that hospitals provide appropriate medical screening. Repp v. Anadarko Mun. Hosp., C.A.10 (Okl.) 1994, 43 F.3d 519.


Emergency room physician's failure to have recognized the magnitude of patient's hand laceration was not a proper claim under Emergency Medical Treatment and Active Labor Act (EMTALA), where the physician followed standard procedure. Ortiz Torres v. Hospital Matilde Brenes, Inc., D.Puerto Rico 2003, 250 F.Supp.2d 9.

Screening and treatment provided by hospital's emergency department to automobile accident victim were adequate under Emergency Medical Treatment and Active Labor Act (EMTALA), even if misdiagnosis occurred, when hospital had clear manual describing internal procedures for treatment of polytraumatized patients like victim and doctor went almost by the book in procedures and treatment administered to victim and, in addition, went beyond what protocol dictated to order treatments not stated therein. Sanchez Rivera v. Doctors Center Hosp., Inc., D.Puerto Rico 2003, 247 F.Supp.2d 90.

Hospital followed its own standard screening procedures when it initially screened a patient in an emergency facility, thus satisfying the screening requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA), despite claim that the hospital failed to perform ancillary medical diagnosis procedures that it routinely made available in its emergency room to screen cardiac-distressed patients; uncontroverted evidence demonstrated that the hospital screened the patient in the same manner that it screened all other patients with similar cardiac symptoms. Bergwall v. MGH Health Services, Inc., D.Md.2002, 243 F.Supp.2d 364.

A hospital's refusal to follow regular screening procedures in a particular instance contravenes the Emergency Medical Treatment and Active Labor Act (EMTALA), but faulty screening, in a particular case, as opposed to disparate screening or refusing to screen at all, does not contravene EMTALA. Roa Gil v. Otero Lopez, D.Puerto Rico 2003, 273 F.Supp.2d 180. Health 258

Patient may maintain suit under Emergency Medical Treatment and Active Labor Act (EMTALA) by showing violation of either medical screening requirement or stabilization before transfer requirement, as provisions are disjunctive. Dollard v. Allen, D.Wyo.2003, 260 F.Supp.2d 1127. Health 658

Medical center's compliance with its own screening procedures, in discharging minor, was adequate, under EMTALA, on claim by personal representative of deceased minor's estate, and immediate family members of minor; variations from standard recording procedures were not so cursory as to fail to alert the physician of the need for medical attention, and the failures occurred after physician made diagnoses, provided treatment, and prescribed medication. Kilroy v. Star Valley Medical Center, D.Wyo.2002, 237 F.Supp.2d 1298.

Fact that hospital performed a number of tests on patient after he presented himself at emergency room with chest pain, including a complete blood count (CBC), an electrocardiogram, and a Creatine Phospokinace test (CPK), did not mean that patient had no cause of action for failure to appropriately screen as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), where hospital failed to show that they complied with their standard procedures when they screen the patient. Torres Otero v. Hospital General Menonita, D.Puerto Rico 2000, 115 F.Supp.2d 253. Health 658

Hospital's failure to weigh emergency room patient and to conduct neuro tests were mere de minimus deviations from hospital's standard screening examination of patient presenting syncope and did not amount to violation of hospital policy for purposes of disparate screening claim under Emergency Medical Treatment and Active Labor Act (EMTALA), in light of extensive screening provided
Requirement of Emergency Medical Treatment and Active Labor Act (EMTALA), that hospital has appropriate screening examination to determine if patient has emergency medical condition, is designed to ensure that hospitals create screening procedures which they apply to all individuals coming to emergency room; EMTALA obliges hospital to create standard emergency room screening procedures based upon hospital's particular needs and circumstances. Tank v. Chronister, D.Kan.1996, 941 F.Supp. 969.

Under Emergency Medical Treatment and Active Labor Act (EMTALA), hospital fulfills "appropriate medical screening" requirement when it conforms its treatment of particular patient to its standard screening procedures; by same token, any departure from standard screening procedures is "inappropriate screening" in violation of EMTALA. Lane v. Calhoun-Liberty County Hosp. Ass'n, Inc., N.D.Fla.1994, 846 F.Supp. 1543.

When hospital does not have standard screening procedure, plaintiff alleging failure to give "appropriate" medical screening in violation of Emergency Medical Treatment and Active Labor Act (EMTALA) has to establish what appropriate medical screening examination, within capability of hospital's emergency department, would have been to determine whether emergency condition existed, and that hospital departed from that appropriate examination; proof of hospital's motive, if any, is not essential element of case but may be relevant. Griffith v. Mt. Carmel Medical Center, D.Kan.1993, 831 F.Supp. 1532.


"Appropriate medical screening examination" that hospital must provide to patients under Comprehensive Omnibus Budget Reconciliation Act (COBRA) provision that prohibits patient dumping by hospitals that receive Medicare funds entitles patient to standard screening procedure accorded by hospital to other patients, without regard to state malpractice law and without regard to hospital's motive; hospital that acts consistently with its customer screening procedure is not liable, even if its procedure would be inadequate under state malpractice law. Jones v. Wake County Hosp. System, Inc., E.D.N.C.1991, 786 F.Supp. 538.

17. Documentation of screening process


18. Emergency condition

Term "symptom," as used in provision of Emergency Medical Treatment and Active Labor Act (EMTALA) defining "emergency medical condition" as "medical condition manifesting itself by acute symptoms of sufficient severity" that immediate medical attention was required, did not include any evidence or communication of information that emergency medical condition could exist, such that hospital's screening duties were triggered by knowledge that accident victim's injuries indicated risk of deep venous thrombosis (DVT), or by combination of victim's statement that he had family history of hypercoagulability and knowledge of his particular injuries. Reynolds v. MaineGeneral Health, C.A.1 (Me.) 2000, 218 F.3d 78. Health 258

Hospital was not liable to emergency room patient under Emergency Medical Treatment and Active Labor Act for failing to stabilize his condition before discharging him; while patient was later found by another hospital to have suffered broken rib and sternum, first hospital had not determined that he had an emergency medical condition, but believed that he was only suffering from muscle spasms, and thus no duty to stabilize an emergency medical condition ever arose. Summers v. Baptist Medical Center Arkadelphia, C.A.8 (Ark.) 1996, 91 F.3d 1132.

Emergency Medical Treatment and Active Labor Act (EMTALA) does not require that patient show that she in fact suffered from emergency medical condition when she arrived at emergency room in order to establish violation; statute directs participating hospital to provide appropriate screening to all who come to its emergency room. Feighery v. York Hosp., D.Me.1999, 59 F.Supp.2d 96.
department, and to prove violation of screening provisions, patient need not prove that she actually suffered from emergency condition when she first arrived, as failure to appropriately screen, by itself, is sufficient as long as other elements are met. Correa v. Hospital San Francisco, C.A.1 (Puerto Rico) 1995, 69 F.3d 1184, certiorari denied 116 S.Ct. 1423, 517 U.S. 1136, 134 L.Ed.2d 547.

Under Emergency Medical Treatment and Active Labor Act (EMTALA), hospital was required to provide respiratory support to anencephalic infant who was brought to hospital in respiratory distress and for whom such treatment was requested; respiratory treatment was "stabilizing care," within meaning of EMTALA, and EMTALA did not carve out exception for anencephalic infants in respiratory distress any more than it carved out such exception for comatose patients, patients with lung cancer, or any other patients possessing underlying medical conditions that severely affected their quality of life and ultimately could result in their death. Matter of Baby K, C.A.4 (Va.) 1994, 16 F.3d 590, certiorari denied 115 S.Ct. 91, 513 U.S. 825, 130 L.Ed.2d 42.

Fact that hospital did not x-ray patient's right hip when he was brought to hospital in unconscious condition did not give rise to civil enforcement action by patient under Emergency Medical Treatment and Active Labor Act for failure to provide "an appropriate medical screening examination * * * to determine whether or not an emergency medical condition * * * exists" where hospital did determine that "emergency medical condition" existed and placed patient in intensive care unit and treated him for 26 days. Collins v. DePaul Hosp., C.A.10 (Wyo.) 1992, 963 F.2d 303.


Patient who arrived at hospital with spontaneous arterial bleeding from left femoral popliteal surgery site while laying in bed and was subsequently diagnosed with pseudoaneurysm and spontaneous hemorrhage at left femoral/popliteal graft site met conditions of Emergency Medical Treatment and Active Labor Act's (EMTALA's) definition of "emergency medical condition," for purposes of patient's estate's action against hospital under EMTALA. Estate of Robbins v. Osteopathic Hosp. Founders Ass'n, N.D.Okla.2000, 178 F.Supp.2d 1221. Health © 658

Infant, who was diagnosed with an acute broncho spasm and cyanosis, was suffering from an "emergency medical condition" within meaning of Emergency Medical Treatment and Active Labor Act (EMTALA) upon his arrival at the emergency room. Pagan-Pagan v. Hospital San Pablo, Inc., D.Puerto Rico 2000, 97 F.Supp.2d 199. Health © 197; Health © 258

Emergency Medical Treatment and Active Labor Act (EMTALA) was not violated when emergency room physician examined patient and sent him home with medication, even though patient died following day; EMTALA was not a malpractice statute, and was satisfied when examination was conducted and physician made medical determination that patient did not have "emergency medical condition." Kenning v. St. Paul Fire and Marine Ins. Co., W.D.Ark.1997, 990 F.Supp. 1104.

Determination by hospital that patient has an emergency medical condition is sufficient basis for liability for improper transfer of patient under Emergency Medical Treatment and Active Labor Act (EMTALA), even if patient's specific medical condition is unknown. Scott v. Hutchinson Hosp., D.Kan.1997, 959 F.Supp. 1351.

Absent any internal injury or any complication of patient's Acquired Immune Deficiency Syndrome (AIDS) condition, small scalp laceration alone did not rise to level of "emergency medical condition" under Emergency Medical Treatment and Active Labor Act (EMTALA), and, as a result, hospital had no duty to stabilize patient prior to discharge. Taylor v. Dallas County Hosp. Dist., N.D.Tex.1996, 959 F.Supp. 373.

Genuine issue of material fact, precluding summary judgment for hospital on claim that it violated Emergency Medical Treatment and Active Labor Act (EMTALA) by discharging patient who came to emergency room complaining of back and chest pain, nausea, spitting up blood, and inability to eat for two days, existed as to whether hospital personnel determined that patient had "emergency medical condition" at time of his release. Brodersen v. Sioux Valley Memorial Hosp., N.D.Iowa 1995, 902 F.Supp. 931.
Where patient was not admitted to hospital in emergency medical condition but rather pursuant to prescheduled arrangements by his private treating physician for purpose of performing esophageal dilatation, and there was no evidence that patient's emergency medical condition was not stabilized at time of patient's transfer to another hospital, patient's representative failed to set forth cause of action against hospital under Emergency Medical Treatment and Active Labor Act (EMTALA). Reynolds v. Mercy Hosp., W.D.N.Y.1994, 861 F.Supp. 214.


Hospital did not violate the Emergency Medical Treatment and Active Labor Act when it discharged patient from emergency room, though physician's differential diagnosis included myocardial infarction and pulmonary embolus, where there was no evidence that physician determined that patient was suffering from anything other than what he listed in the medical report as his diagnosis: costochondritis and hyperventilation syndrome. Harris v. Health & Hosp. Corp., S.D.Ind.1994, 852 F.Supp. 701.

Medical center did not violate Emergency Medical Treatment and Active Labor Act (EMTALA) when it transferred patient to another hospital before patient gave birth, despite patient's claim that hospital's actions were proximate cause of severe brain damage and profound mental retardation sustained by infant, because she had no insurance and transferred patient without obtaining necessary signed certification of physician; nowhere in statute did it state that individual in emergency medical condition or in active labor had to enter through emergency room or be sent to emergency room for determination of individual status. McIntyre v. Schick, E.D.Va.1992, 795 F.Supp. 777.


Hospital could not be held liable under "anti-dumping" statute for failing to diagnose indigent patient's meningitis, absent indication that hospital knowingly failed to conduct appropriate medical examination or that examining physician knew that patient suffered from emergency medical condition. Deberry v. Sherman Hosp. Ass'n, N.D.Ill.1991, 769 F.Supp. 1030, reconsideration denied 775 F.Supp. 1159.

Once it is established that a patient showed up at a hospital's emergency room with an emergency medical condition, the hospital can violate the Federal Emergency Medical Treatment and Active Labor Act either by failing to detect the nature of the emergency condition through inadequate screening procedures or if the emergency nature of the patient's condition is detected, by failing to stabilize the condition before releasing the patient. Deberry v. Sherman Hosp. Ass'n, N.D.Ill.1990, 741 F.Supp. 1302.
Extremely hypertensive woman was in "active labor" within meaning of Emergency Medical Treatment and Active Labor Act (EMTALA) where, by time hospital physician authorized her transfer, there was inadequate time to safely transfer her to another hospital before she delivered her baby. Burditt v. U.S. Dept. of Health and Human Services, C.A.5 1991, 934 F.2d 1362.

Stabilization of condition

Genuine issues of material fact as to whether patient diagnosed with steroid-induced psychosis was stabilized when discharged from emergency room, whether such psychosis could be adequately addressed simply by directing the patient to immediately cease taking the steroid, and whether the hospital's actions, or lack thereof, were causally related to patient's death, precluded summary judgment, in action brought by widower of psychiatric patient against hospital, for violation of the Emergency Medical Treatment and Active Labor Act (EMTALA). Thomas v. Christ Hosp. and Medical Center, C.A.7 (Ill.) 2003, 328 F.3d 890. Federal Civil Procedure 2481

Patient who suffered from life-threatening traumatic injury to his abdominal aorta was not "stabilized," as required before transfer from hospital with capability and capacity to treat patient could refuse request for transfer by transferor hospital under reverse-dumping provisions of Emergency Medical Treatment and Active Labor Act (EMTALA). St. Anthony Hosp. v. U.S. Dept. of Health and Human Services, C.A.10 2002, 309 F.3d 680. Health 258

Newborn's arrival in covered hospital's operating room and hospital's prompt detection of emergency medical condition, if proven, was sufficient to trigger hospital's obligations under Emergency Medical Treatment and Active Labor Act (EMTALA) to stabilize newborn and refrain from transferring him except in compliance with EMTALA's provisions, and therefore district court had jurisdiction over parents' EMTALA claim, which arose from newborn's death following his transfer to different hospital, despite absence of emergency room presentment. Lopez-Soto v. Hawayek, C.A.1 (Puerto Rico) 1999, 175 F.3d 170. Health 658

Hospital's antiresuscitation order and failure to prevent patient's death did not violate Emergency Medical Treatment and Active Labor Act (EMTALA) where antiresuscitation order was entered 12 days after patient had been admitted to hospital, and patient received stabilizing treatment in accord with EMTALA for 12 days following her admission. Bryan v. Rectors and Visitors of University of Virginia, C.A.4 (Va.) 1996, 95 F.3d 349.

Allegations by administrator of estate of patient who received treatment for severe scalp laceration at emergency room with staple sutures and who died short time later of cerebral herniation and hematoma that hospital did not take further steps to examine or treat patient or in any way attempt to stabilize condition and that patient was discharged before condition was stabilized were insufficient to state stabilization claim under Emergency Medical Treatment and Active Labor Act (EMTALA); physician did diagnose and treat patient, and complaint did not allege that hospital and physician perceived seriousness of condition and failed to stabilize it. Vickers v. Nash General Hosp., Inc., C.A.4 (N.C.) 1996, 78 F.3d 139.

Stabilization provision of Emergency Medical Treatment and Active Labor Act (EMTALA) on its face takes actual diagnosis as given and only obligates hospitals to stabilize conditions that they actually detect; stabilization claim exists when patient had emergency condition and hospital actually knew of that condition, and does not hold hospitals accountable for failing to stabilize conditions of which they are not aware, or even conditions of which they should have been aware, as EMTALA would otherwise become coextensive with malpractice claims for negligent treatment. Vickers v. Nash General Hosp., Inc., C.A.4 (N.C.) 1996, 78 F.3d 139.

Hospital did not violate Emergency Medical Treatment and Active Labor Act (EMTALA) section requiring hospital to provide whatever treatment, within its capabilities, is needed to stabilize person suffering from "emergency medical condition" before transferring or discharging that person; even though patient died after discharge, there was no evidence that patient was in emergency medical condition when discharged or that hospital knew of emergency condition, patient told doctors at time of discharge that she was feeling better, and her vital signs had stabilized. Holcomb v. Monahan, C.A.11 (Ala.) 1994, 30 F.3d 116.

Patient's condition was stabilized, and thus patient's relatives could not recover under Emergency Medical
Treatment and Active Labor Act (EMTALA) for patient's subsequent death; relatives did not rebut hospital's evidence establishing that when she was discharged, patient was ambulatory, with no acute distress, and with stable vital signs. Green v. Touro Infirmary, C.A.5 (La.) 1993, 992 F.2d 537.

Hospital did not violate Emergency Medical Treatment and Active Labor Act by transferring patient who was in critical condition with arterial blockage to another hospital for bypass surgery; hospital stabilized patient prior to transfer through insertion of intraaortic balloon pump to aid her heart and was not required to completely alleviate patient's emergency condition. Brooker v. Desert Hosp. Corp., C.A.9 (Cal.) 1991, 947 F.2d 412.


Patient failed to establish that he was discharged from hospital prior to having his heel injury stabilized, as required to state a claim under the Emergency Medical Treatment and Active Labor Act (EMTALA), where treating specialist provided initial emergency care, discharged patient, and instructed patient to return for follow-up care. Frazier v. Angel Medical Center, W.D.N.C.2004, 308 F.Supp.2d 671.

Patient's emergency medical condition was stabilized prior to his discharge from hospital and thus patient could not recover against hospital and treating physicians under the Emergency Medical Treatment and Active Labor Act (EMTALA); patient was admitted to hospital with emergency medical condition of sore throat, sinus pressure, swollen glands, achiness, painful swallowing and trouble breathing, admitting physician documented improvement of condition over five days that patient remained at hospital, and patient presented no evidence that admission was a subterfuge to avoid EMTALA liability. Mazurkiewicz v. Doylestown Hosp., E.D.Pa.2004, 305 F.Supp.2d 437.

Hospital had no duty under Emergency Medical Treatment and Active Labor Act (EMTALA) to stabilize patient who died several days after being released from emergency room, where, at time of patient's discharge, patient was only showing a slightly elevated blood pressure, which was not an emergency condition. Heirs of Medero v. Susoni, D.Puerto Rico 2003, 281 F.Supp.2d 352, vacated in part 2004 WL 2756854.

Liability under the Emergency Medical Treatment and Active Labor Act (EMTALA) for failure to stabilize does not hinge on the result of the plaintiff's condition after the release, but rather or whether the hospital would have considered another patient in the same condition as too unstable to warrant his or her release or transfer. Heirs of Medero v. Susoni, D.Puerto Rico 2003, 281 F.Supp.2d 352, vacated in part 2004 WL 2756854.

Hospital did not violate stabilization requirement of Emergency Medical Treatment and Active Labor Act (EMTALA) with respect to patient who suffered cerebral infarct after his release, where hospital's screening was neither inadequate nor inequitable, and hospital determined pursuant to that screening that patient was not suffering from emergency medical condition. Dominguez-Perez v. Hospital Auxilio Mutuo, D.Puerto Rico 2003, 275 F.Supp.2d 135.

Hospital did not violate stabilization before transfer requirement of Emergency Medical Treatment and Active Labor Act (EMTALA) by discharging low back pain patient before treating her emergency medical condition, where hospital did not have actual knowledge of that patient was actually suffering from extremely rare, emergency neurological disorder of cauda equina syndrome, rather than more typical low back pain problem. Dollard v. Allen, D.Wyo.2003, 260 F.Supp.2d 1127.

Medical center did not have duty to stabilize minor, under EMTALA, where physician determined after screening that no emergency medical condition existed. Kilroy v. Star Valley Medical Center, D.Wyo.2002, 237 F.Supp.2d 1298.

In determining whether patient has been stabilized for purposes of duty under the Emergency Medical Treatment and Active Labor Act (EMTALA) to stabilize before releasing or transferring patient, fact-finder must consider whether the medical treatment and subsequent release were reasonable in view of the circumstances that existed at the time the hospital discharged or transferred the individual. Torres Otero v. Hospital General Menonita, D.Puerto Rico 2000, 115 F.Supp.2d 253.
Screening obligation under the Emergency Medical Treatment and Active Labor Act (EMTALA) applies only to individuals who present themselves at a hospital's emergency room, whereas the duty to stabilize is triggered when any individual comes to a hospital and the hospital determines that the individual has an emergency medical condition. Torres Otero v. Hospital General Menonita, D. Puerto Rico 2000, 115 F. Supp. 2d 253. Health 197; Health 258

Under the Emergency Medical Treatment and Active Labor Act (EMTALA), duty to stabilize emergency room patient is greater than the duty to screen. Fuentes Ortiz v. Mennonite General Hospital, D. Puerto Rico 2000, 106 F. Supp. 2d 327. Health 197; Health 258

Emergency room physician fulfilled duty under Emergency Medical Treatment and Active Labor Act (EMTALA) to adequately stabilize condition of patient suffering from neutropenia and thrombocytopenia by treating patient with antibiotics, drug to rebuild white blood cells, potassium supplements and intravenous fluids. Kileup v. Adventist Health, Inc., N. D. Cal. 1999, 57 F. Supp. 2d 925, affirmed 232 F. 3d 894. Health 197; Health 258

To determine whether patient was "stable" before being transferred by hospital emergency room, as required for hospital to comply with Emergency Medical Treatment and Active Labor Act (EMTALA), court must look at patient's condition at time of transfer or discharge. Torres Nieves v. Hospital Metropolitanano, D. Puerto Rico 1998, 998 F. Supp. 127.

Even if hospital had duty under Emergency Medical Treatment and Active Labor Act (EMTALA) to stabilize Human Immunodeficiency Virus (HIV) positive patient with scalp laceration prior to discharge, hospital satisfied requirement of EMTALA that, within reasonable medical probability, no material deterioration of patient's condition should occur following discharge, by suturing laceration, prescribing pain killer, and transferring patient home by ambulance; although patient was unable to sign discharge form, this was consistent with his disorientation attributable to Acquired Immune Deficiency Syndrome (AIDS) dementia. Taylor v. Dallas County Hosp. Dist., N. D. Tex. 1996, 959 F. Supp. 373.

If hospital determines that individual has emergency medical condition, pursuant to Emergency Medical Treatment and Active Labor Act (EMTALA), hospital must either provide further examination and treatment so as to "stabilize" patient's treatment before discharging patient, or transfer individual to another medical facility; however, except under certain circumstances, hospital may not transfer individual unless individual's condition has stabilized. Jones v. Garcia, M. D. Fla. 1996, 936 F. Supp. 929.

No violation of Emergency Medical Treatment and Active Labor Act (EMTALA) was established by evidence that patient was treated in emergency department over six-hour period for recurrent acute pancreatitis and was then admitted and developed complications leading to her death at least eight hours after admission, allegedly because doctors failed to respond to nursing staff request to examine patient and consequently failed to diagnose and treat complications; proof did not establish or permit inference that hospital failed to stabilize original emergency medical condition to point that it would not materially deteriorate during, or as result of, transfer to another hospital. Hussain v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc., E. D. Va. 1996, 914 F. Supp. 1331.

No evidence supported claim under Emergency Medical Treatment and Active Labor Act (EMTALA) based on hospital's treatment of emergency room patient; hospital's medical records showed that patient was provided full medical screening examination and was determined by medical staff to be stable before she was released. Robinson v. Henry Ford Health Systems, E. D. Mich. 1994, 892 F. Supp. 176, affirmed 86 F. 3d 1156.

Patient who suffered various injuries in automobile accident failed to show that his emergency medical condition was not "stabilized" when defendant hospital transferred him to second hospital and, thus, defendant hospital did not thereby violate Emergency Medical Treatment and Active Labor Act (EMTALA); while one physician testified that patient's condition was potentially life threatening at time of transfer, EMTALA required proof that material deterioration of condition was likely, within reasonable medical probability. Deron v. Wilkins, S. D. Miss. 1995, 879 F. Supp. 603.

Refusal to provide ventilator treatment to an anencephalic infant would violate Emergency
Medical Treatment and Active Labor Act (EMTALA), hospital would be liable under EMTALA if baby arrived in respiratory distress, from which she sometimes suffered, and hospital failed to provide mechanical ventilation or some other treatment necessary to stabilize her acute condition. Matter of Baby K, E.D.Va.1993, 832 F.Supp. 1022, affirmed 16 F.3d 590, certiorari denied 115 S.Ct. 91, 513 U.S. 825, 130 L.Ed.2d 42.

No violation of the Emergency Medical Treatment and Active Labor Act (EMTALA) was established on theory that hospital discharged patient with emergency medical condition who had not been stabilized; though patient later died, it was not demonstrated that emergency condition existed at time of discharge and record indicated that at time of discharge patient's vital signs had returned to normal and she stated that she was feeling better. Holcomb v. Humana Medical Corp., Inc., M.D.Ala.1993, 831 F.Supp. 829, affirmed 30 F.3d 116.

Hospital was not in violation of provision of Patient Anti-Dumping Act requiring hospital to provide necessary stabilizing treatment to any patient that hospital determines has emergency medical condition by failing to provide stabilizing treatment to child who had choked on peanut, where hospital determined that child did not have medical emergency condition. Anadumaka By and Through Anadumaka v. Edgewater Operating Co., N.D.Ill.1993, 823 F.Supp. 507.

21. ---- Transfer, stabilization of condition

There was no duty under Emergency Medical Treatment and Active Labor Act (EMTALA) to provide stabilizing treatment to a patient with an emergency medical condition who was not transferred. Harry v. Marchant, C.A.11 (Fla.) 2002, 291 F.3d 767.

Requirement under Emergency Medical Treatment and Active Labor Act (EMTALA) that patient's emergency medical condition be stabilized was not conditioned upon subsequent transfer of patient, but rather arose once hospital determined that emergency condition existed, and continued until patient was stabilized for transfer, release, or admission. Harry v. Marchant, C.A.11 (Fla.) 2001, 237 F.3d 1315, rehearing granted, opinion vacated 259 F.3d 1310, opinion reinstated in part on rehearing 291 F.3d 767.

Evidence established that a hospital stabilized a patient prior to transfer from an emergency facility, as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), despite claim that the patient's blood circulation was abnormal as evidenced by the pain she was suffering, and that the hospital failed to pursue appropriate ancillary procedures; when physicians first determined to transfer the patient, they believed, within a reasonable degree of medical probability, that her condition would not materially deteriorate during the transfer, and multiple experts agreed that her condition remained materially unchanged, indeed actually improved, during the time between the decision to move her and her actual transfer. Bergwall v. MGH Health Services, Inc., D.Md.2002, 243 F.Supp.2d 364.

Hospital's failure to timely treat patient's emergency medical conditions did not violate its duty to stabilize under Emergency Medical Treatment and Active Labor Act (EMTALA), where patient was never discharged or transferred from emergency room. Estate of Giomard Rivera v. Doctor Susoni Hosp., Inc., D.Puerto Rico 2003, 288 F.Supp.2d 161.

Hospital did not violate stabilization before transfer requirement of Emergency Medical Treatment and Active Labor Act (EMTALA) by discharging low back pain patient before treating her emergency medical condition, where hospital did not have actual knowledge of that patient was actually suffering from extremely rare, emergency neurological disorder of cauda equina syndrome, rather than more typical low back pain problem. Dollard v. Allen, D.Wyo.2003, 260 F.Supp.2d 1127. Health 658

Hospital did not violate stabilization before transfer requirement of Emergency Medical Treatment and Active Labor Act (EMTALA) in discharging low back pain patient who had undetected emergency medical condition, as stabilization requirement did not apply to individuals, like patient, who had been admitted to hospital for inpatient care. Dollard v. Allen, D.Wyo.2003, 260 F.Supp.2d 1127. Health 658

Once patient has been screened properly in emergency room, has been admitted to hospital for treatment, and is receiving treatment, transfer provisions of Emergency Medical Treatment and Active Labor Act (EMTALA) no longer apply. Scott v. Hutchinson Hosp., D.Kan.1997, 959 F.Supp. 1351.

22. ---- Standard procedures, stabilization of condition

Under provision of Emergency Medical Treatment and Active Labor Act (EMTALA) requiring that hospital provide "medical treatment within its capacity which minimizes the risks to the individual's health" when transferring individual whose emergency medical condition had not been stabilized, medical center's capacity to provide medical treatment to minimize risks of transfer was measured by center's standard practices; therefore, to establish that center's transfer of gunshot victim was not "appropriate" under EMTALA, victim's mother had to show that treating physician violated existing procedure or requirement by failing to insert chest tubes prior to victim's transfer. Ingram v. Muskogee Regional Medical Center, C.A.10 (Okla.) 2000, 235 F.3d 550. Health 658

Hospital's duty under Emergency Medical Treatment and Active Labor Act (EMTALA) to provide stabilizing treatment for emergency medical condition is broader than its duty to provide appropriate medical screening; thus, hospital may not avoid duty to provide stabilizing treatment by providing uniform treatment for all patients with same condition, if that uniform treatment will allow patients with those conditions to materially deteriorate. Matter of Baby K, C.A.4 (Va.) 1994, 16 F.3d 590, certiorari denied 115 S.Ct. 91, 513 U.S. 825, 130 L.Ed.2d 42.

Genuine issues of material fact as to whether a hospital stabilized a patient prior to discharging him precluded summary judgment for hospital on failure to stabilize claims asserted by patient's widow and siblings under the Emergency Medical Treatment and Active Labor Act (EMTALA); lab results that a doctor allegedly relied upon to discharge the patient, showing he had some type of virus, were missing in the medical record. Marrero v. Hospital Hermanos Melendez, Inc., D.Puerto Rico 2003, 253 F.Supp.2d 179. Federal Civil Procedure 2481

Hospital's alleged failure to provide appropriate treatment for emergency patient's cardiac problems did not violate Emergency Medical Treatment and Active Labor Act (EMTALA) in absence of showing that hospital did not follow its own standard practices for treating patients with similar conditions. Scott v. Hutchinson Hosp., D.Kan.1997, 959 F.Supp. 1351.

Genuine issues of material fact, precluding summary judgment for hospital in action under Emergency Medical Treatment and Active Labor Act (EMTALA) by estate of patient who came to hospital complaining of chest pains, nausea, and spitting up blood, and who was told to return in four hours, existed as to whether hospital provided patient with treatment that deviated from hospital's standard procedures by failing to perform electrocardiogram (EKG) on patient, and by failing to place him in hospital's cardiac unit. Brodersen v. Sioux Valley Memorial Hosp., N.D.Iowa 1995, 902 F.Supp. 931.

23. Ambulance

Genuine issues of material fact, precluding summary
judgment for hospital on claim that it violated Emergency Medical Treatment and Active Labor Act's (EMTALA) transfer provision by transporting burn patient to burn center, existed as to whether patient was stable at time of transfer, and as to whether transfer by mobile ambulance, rather than by air ambulance, was inappropriate. Smith v. Janes, S.D.Miss.1995, 895 F.Supp. 875.

Hospital did not violate Anti-Dumping Act by permitting emergency room patient to be transferred to another hospital by private car, rather than ambulance; transfer by private vehicle was medically appropriate, and transfer by ambulance was not "service" provided by hospital, since it did not own or control an ambulance. Wey v. Evangelical Community Hosp., M.D.Pa.1993, 833 F.Supp. 453.

Automobile with no medical equipment, whose only occupant other than indigent patient in labor was her boyfriend, was not equivalent of "ambulance" for purposes of Anti-Dumping Act. Owens v. Nacogdoches County Hosp. Dist., E.D.Tex.1990, 741 F.Supp. 1269.

24. Consent to transfer

Fact that patient who suffered broken leg and other injuries in automobile accident voluntarily signed a waiver before leaving to go to another hospital after waiting for hours to receive treatment did not preclude finding that patient was transferred before she was stabilized in violation of the Emergency Medical Treatment and Active Labor Act (EMTALA). Malave Sastre v. Hospital Doctor's Center, Inc., D.Puerto Rico 2000, 93 F.Supp.2d 105. Health 258

Hospital did not violate Anti-Dumping Act by failing to have emergency room patient sign consent-to-transfer form before he was transported to another hospital; patient and his wife made remarks which indicated they agreed to transfer, and failure to have patient sign consent form was result of misunderstanding between physician and emergency room nurse. Wey v. Evangelical Community Hosp., M.D.Pa.1993, 833 F.Supp. 453.

25. Reverse dumping

Physician had actual authority, under Oklahoma law, to accept or refuse transfer to hospital of unstabilized patient suffering from life-threatening traumatic injury to his abdominal aorta, and thus hospital was bound by physician's refusal in violation of reverse-dumping provisions of Emergency Medical Treatment and Active Labor Act (EMTALA). St. Anthony Hosp. v. U.S. Dept. of Health and Human Services, C.A.10 2002, 309 F.3d 680. Health 258

On-call thoracic surgeon's refusal to accept transfer of unstabilized patient suffering from life-threatening traumatic injury to his abdominal aorta was not exercise of medical judgment excusing hospital's violation of Emergency Medical Treatment and Active Labor Act's (EMTALA) reverse-dumping provisions; surgeon's testimony that he had received erroneous information concerning patient's condition was not credible. St. Anthony Hosp. v. U.S. Dept. of Health and Human Services, C.A.10 2002, 309 F.3d 680. Health 258

Transferor hospital's notification to requested transferee hospital that transferor hospital had made other arrangements for unstabilized patient suffering from life-threatening traumatic injury to his abdominal aorta was not withdrawal of transfer request, since transferee hospital had already refused request in violation of reverse-dumping provisions of Emergency Medical Treatment and Active Labor Act (EMTALA). St. Anthony Hosp. v. U.S. Dept. of Health and Human Services, C.A.10 2002, 309 F.3d 680. Health 258

Physician at transferor hospital requested transfer of unstabilized patient suffering from life-threatening traumatic injury to his abdominal aorta to transferee hospital, as required to trigger reverse-dumping provisions of Emergency Medical Treatment and Active Labor Act (EMTALA); plain meaning of transferor physician's statements was that patient was suffering from emergency condition that needed to be treated immediately with surgery and that physician was seeking to transfer patient to transferee hospital. St. Anthony Hosp. v. U.S. Dept. of Health and Human Services, C.A.10 2002, 309 F.3d 680. Health 258

26. Certification requirement

The requirement of the Emergency Medical Treatment and Active Labor Act (EMTALA) for certification, upon transfer of patient to another hospital, that the medical benefits reasonably expected from the provision of appropriate medical treatment outweigh the risks to the individual, did not apply where transferring hospital had stabilized the only emergency medical condition that it detected;

Hospital was not liable under Emergency Medical Treatment and Active Labor Act (EMTALA) despite technical deficiency of doctor's failure to include written summary of specific risks of transfer on transfer certificate, as doctor actually weighed risks and benefits of transfer, failure to write down risks was not direct cause of patient's harm, patient received appropriate medical screening exam, and doctor certified that benefits outweighed risks and summarized benefits. Vargas By and Through Gallardo v. Del Puerto Hosp., C.A.9 (Cal.) 1996, 98 F.3d 1202.

27. Facilities of transferee hospital

Physician violated transfer requirements of Emergency Medical Treatment and Active Labor Act (EMTALA) when he effected transfer of severely hypertensive woman in active labor to hospital 170 miles away in ambulance that met state-licensing requirements but which did not include all equipment reasonably medically necessary for safe transfer of particular patient; although obstetrical nurse and emergency medical technicians who accompanied woman in transit were qualified to deliver her baby in absence of complications, it was undisputed that they were unqualified to perform cesarean section or treat other complications from mother's hypertension that could have developed; substantial evidence supported administrative finding that only physician could have fulfilled "qualified personnel" requirement of Act and that equipment was deficient since fetal heart monitor was not included in transfer equipment. Burditt v. U.S. Dept. of Health and Human Services, C.A.5 1991, 934 F.2d 1362.

Facilities of transferee hospital, including neo-natal unit, did not justify defendant hospital's transfer of indigent adolescent in labor to transferee hospital, which was 200 miles away; only serious medical risk identified by physician in admitting adolescent for delivery at defendant hospital was possible stunted growth of baby, which physician subsequently admitted was not his concern at time, and there was risk that, had baby been born on side of road, adolescent and baby may have died. Owens v. Nacogdoches County Hosp. Dist., E.D.Tex.1990, 741 F.Supp. 1269.

28. Discharge of patient


Death of infant while being treated at hospital for an emergency medical condition precluded possibility of Emergency Medical Treatment and Active Labor Act (EMTALA) liability because no transfer or release was ordered prior to infant being stabilized. Pagan-Pagan v. Hospital San Pablo, Inc., D.Puerto Rico 2000, 97 F.Supp.2d 199. Health © 2010 Thomson Reuters. No Claim to Orig. US Gov. Works.


Federal Anti-Dumping Act could apply to discharge of hospital patient who was not admitted to hospital's emergency room. Helton v. Phelps County Regional Medical Center, E.D.Mo.1992, 794 F.Supp. 332.

29. Suicide

Hospital's failure to treat mental health patient was not proximate cause of patient's suicide, and hospital was not liable under Emergency Medical Treatment and Active Labor Act (EMTALA), since, under Ohio law, finding of proximate cause was precluded by time lapse of over one month and intervening treatment by two providers between patient's visit to hospital and his suicide. Tolton v. American Biodyne, Inc., C.A.6 (Ohio) 1995, 48 F.3d 937.

Hospital's diagnosis and treatment of physical condition of patient who had sought treatment in emergency room for physical complaints, during which she said that she had contemplated suicide because of pain, was medical screening examination designed to diagnose emergency medical condition, and thus, patient could not show failure to provide appropriate medical screening examination and could not recover under Emergency Medical Treatment and Active Labor Act (EMTALA) in action brought after she later attempted suicide, even though hospital had

Hospital and its emergency room physicians were not liable under Emergency Medical Treatment and Active Labor Act (EMTALA) for suicide death of mental patient, where patient was not alleged to be in imminent danger of death at either time he was seen in emergency room, and patient was never denied treatment due to inability to pay or lack of insurance. Tolton v. American Biodyne, Inc., N.D.Ohio 1993, 854 F.Supp. 505, affirmed 48 F.3d 937.

30. Elements of cause of action

To prove transfer violation under stabilization provisions of Emergency Medical Treatment and Active Labor Act (EMTALA), the government must show in a civil penalty case not only that the transferred patient was not "stabilized" and not accepted by the receiving hospital, but also show that the doctor was "negligent" in transferring the patient in the sense that, under the circumstances, the physician knew or should have known that the benefits of transfer did not outweigh the risks. Cherukuri v. Shalala, C.A.6 1999, 175 F.3d 446. Health 197

To establish violation of Emergency Medical Treatment and Active Labor Act (EMTALA), patient must show that hospital is participating hospital covered by EMTALA that operates emergency department or equivalent treatment facility, that patient arrived at facility seeking treatment, and that hospital either did not afford patient appropriate screening in order to determine if she had emergency medical condition or bade farewell to patient, whether by turning her away, discharging her, or improvidently transferring her, without first stabilizing her emergency condition. Correa v. Hospital San Francisco, C.A.1 (Puerto Rico) 1995, 69 F.3d 1184, certiorari denied 116 S.Ct. 1423, 517 U.S. 1136, 134 L.Ed.2d 547.

Plaintiff suing under the Emergency Medical Treatment and Active Labor Act (EMTALA) must show, as a threshold matter, that the hospital is a participating hospital, covered by EMTALA, that operates an emergency department (or an equivalent treatment facility). Feliciano Rivera v. Medical & Geriatric Administrative Services, Inc., D.Puerto Rico 2003, 254 F.Supp.2d 237. Health 658

Recovery under Emergency Medical Treatment and Active Labor Act (EMTALA) is expressly limited to circumstances in which plaintiff did not receive "appropriate" screening and/or was not "stabilized" before being transferred or discharged. Griffith v. Mt. Carmel Medical Center, D.Kan.1993, 831 F.Supp. 1532.

To overcome motion to dismiss under Emergency Treatment and Active Labor Act, plaintiff must allege that: (1) plaintiff went to defendant's emergency room; (2) he/she had emergency medical condition, and either (3) hospital did not adequately screen him/her to determine whether he/she had such condition, or (4) discharged or transferred him/her before emergency condition had been stabilized. Huckaby v. East Alabama Medical Center, M.D.Ala.1993, 830 F.Supp. 1399.

Plaintiff stated cause of action against hospital under Emergency Treatment and Active Labor Act; plaintiff alleged that patient went to hospital emergency room suffering from stroke and was transferred to another hospital before her condition was stabilized. Huckaby v. East Alabama Medical Center, M.D.Ala.1993, 830 F.Supp. 1399.

31. ---- Causation, elements of cause of action

To recover for disparate treatment in screening under the Emergency Medical Treatment and Active Labor Act (EMTALA), the plaintiff must proffer evidence sufficient to support a finding that he or she received materially different screening than that provided to others in his or her condition; it is not enough to proffer expert testimony as to what treatment should have been provided to a patient in plaintiff's position. Roa Gil v. Otero Lopez, D.Puerto Rico 2003, 273 F.Supp.2d 180. Health 823(2)

Mere fact that a private hospital transfers a stable patient to a public hospital, where she later encounters faulty medical care, cannot establish a causal link between the private hospital's actions and the damages suffered by the patient which will provide basis for recovery under Emergency Medical Treatment and Active Labor Act (EMTALA). Torres Nieves v. Hospital Metropolitano, D.Puerto Rico 1998, 998 F.Supp. 127.

32. ---- Knowledge, elements of cause of action

To establish violation of stabilization and transfer provision of Emergency Medical Treatment and Active Labor Act (EMTALA), plaintiff must show

Hospital that did not know of patient's emergency medical condition at time of transfer could not have violated Emergency Medical Treatment and Active Labor Act (EMTALA) by transferring patient without having stabilized emergency medical condition. Baber v. Hospital Corp. of America, C.A.4 (W.Va.) 1992, 977 F.2d 872.

Plaintiff seeking to show a violation of provisions of Emergency Medical Treatment and Active Labor Act (EMTALA) covering hospital's duty to stabilize patients with emergency conditions and responsibilities with respect to transfers of such patients must show that hospital had actual knowledge of patient's emergency medical condition, but actual knowledge is not required to show violation of EMTALA provision requiring hospital to conduct appropriate medical screening examination of individual seeking emergency room treatment, inasmuch as screening usually precedes conclusion that an emergency condition exists. Sanchez Rivera v. Doctors Center Hosp., Inc., D.Puerto Rico 2003, 247 F.Supp.2d 90.

To prove violation of provision of Emergency Medical Treatment and Active Labor Act (EMTALA) governing patient transfers, plaintiff must show not only that transferred patient was not stabilized and was not accepted by receiving hospital, but also that doctor was negligent in transferring patient in the sense that, under the circumstances, physician knew or should have known that the benefits of transfer did not outweigh the risks. Sanchez Rivera v. Doctors Center Hosp., Inc., D.Puerto Rico 2003, 247 F.Supp.2d 90.

Pregnant patient who miscarried after being discharged from hospital emergency room could not establish that hospital was aware of an emergency medical condition, as would have triggered its duty to stabilize patient under Emergency Medical Treatment and Active Labor Act (EMTALA); hospital records demonstrated that patient presented only with "slight abdominal pains" and "no vaginal bleeding," that test for ruptured membranes was negative, and that she was not in premature labor. Brenord v. Catholic Medical Center of Brooklyn and Queens, Inc., E.D.N.Y 2001, 133 F.Supp.2d 179. Health 658

Since infant was released from hospital in good condition during the morning hours, hospital did not breach its duty under Emergency Medical Treatment and Active Labor Act (EMTALA) to stabilize infant before releasing him in the morning; at the time of his release, hospital had no actual knowledge that infant was in an emergency condition. Pagan-Pagan v. Hospital San Pablo, Inc., D.Puerto Rico 2000, 97 F.Supp.2d 199. Health 258


While Emergency Medical Treatment and Active Labor Act (EMTALA) requires that hospital which determines that individual has emergency medical condition provide such further examination and treatment as required to stabilize condition, requirement takes actual diagnosis as given and only obligates hospitals to stabilize conditions they actually detect, and does not hold hospitals accountable for failing to stabilize conditions of which they were not aware or should have been aware, since EMTALA would otherwise become coextensive with malpractice claims for negligent treatment. Gerber v. Northwest Hosp. Center, Inc., D.Md.1996, 943 F.Supp. 571.

Hospital that received patient in its emergency room and transferred him to its intensive care unit based on determination that emergency medical condition existed was not liable under Emergency Medical Treatment Active Labor Act (EMTALA) for failure to stabilize patient prior to transfer to another hospital based on alleged failure to diagnose collapsed lung and torn renal artery; while hospital knew that emergency medical condition existed, there was no evidence that hospital had specific knowledge of collapsed lung or torn renal artery prior to transfer. Green v. Reddy, D.Kan.1996, 918 F.Supp. 329.


33. ---- Motive, elements of cause of action

No showing of improper motive on part of hospital is required to establish violation of requirement under Emergency Medical Treatment and Active Labor Act (EMTALA) that hospital provide necessary

Whether hospital's treatment of emergency room patient was influenced by a perceived lack of insurance coverage was irrelevant in determining whether hospital failed to treat patient in manner consistent with its existing procedures for patients with like conditions and thus violated Emergency Medical Treatment and Active Labor Act (EMTALA). Phillips v. Hillcrest Medical Center, C.A.10 (Okla.) 2001, 244 F.3d 790, certiorari denied 122 S.Ct. 1203, 535 U.S. 905, 152 L.Ed.2d 142, rehearing denied 122 S.Ct. 1811, 535 U.S. 1043, 152 L.Ed.2d 666. Health 258

Patient's guardian failed to establish that patient's discharge from hospital to nursing care facility before patient's condition was stabilized was caused by financial considerations, as required to maintain cause of action against hospital under Emergency Medical Treatment and Labor Act (EMTALA). Roberts v. Galen of Virginia, Inc., C.A.6 (Ky.) 1997, 111 F.3d 405, certiorari granted in part 118 S.Ct. 2295, 524 U.S. 915, 141 L.Ed.2d 156, reversed 119 S.Ct. 685, 525 U.S. 249, 142 L.Ed.2d 648, on remand 187 F.3d 637.

Although proof of bad motive or nonmedical reason is not required to establish disparate treatment claim under Emergency Medical Treatment and Active Labor Act (EMTALA), hospital may, after plaintiff makes threshold showing of differential treatment, offer rebuttal evidence either by demonstrating that patient was accorded same level of treatment that all patients received or that test or procedure was not given because physician did not believe that test was reasonable or necessary under particular circumstances of that patient; if hospital offers such rebuttal evidence, plaintiff is allowed to challenge medical judgment of physicians involved through his or her own medical testimony. Power v. Arlington Hosp. Ass'n, C.A.4 (Va.) 1994, 42 F.3d 851.

Evidence that hospital had violated accepted medical practice by failing to provide adequate screening to patient who arrived at hospital complaining of abdominal pain, and that hospital personnel had "kicked" patient out of hospital, did not establish that hospital's actions had been motivated by patient's lack of insurance or any other improper motive, as required to give rise to claim under Emergency Medical Treatment and Active Labor Act (EMTALA). Adams v. Grace Hosp., E.D.Mich.1997, 962 F.Supp. 101.

Plaintiff stated claim under Emergency Medical Treatment and Active Labor Act (EMTALA) by alleging that hospital operated emergency department, that her decedent presented himself for treatment in department, and that hospital either did not afford him appropriate screening or that he was discharged before his emergency medical condition was stabilized, and it was not necessary to ascribe hospital's actions to some economic motive. Hart v. Mazur, D.R.I.1995, 903 F.Supp. 277.

Allegations in complaint failed to establish that stabilizing process used by hospital in treating patient who visited emergency room after being injured in brawl constituted violation of Emergency Medical Treatment and Active Labor Act (EMTALA) where there was no indication that hospital released patient with any bad faith or purpose of disparate treatment and there was no evidence that hospital treated patient differently than it would treat any other patient or that it deviated from its standard screening or stabilizing procedure, even though facts supported finding that gross misdiagnosis of patient's condition occurred. Vickers v. Nash General Hosp., Inc., E.D.N.C.1995, 875 F.Supp. 313, affirmed 78 F.3d 139.

To state claim under Emergency Medical Treatment and Active Labor Act (EMTALA), patient's survivor was not required to allege that hospital had economic motive for failing to screen or for discharging patient. Lane v. Calhoun-Liberty County Hosp. Ass'n, Inc., N.D.Fla.1994, 846 F.Supp. 1543.

Hospital's motive is not relevant to determination whether patient has stated claim under Emergency Medical Treatment and Active Labor Act (EMTALA). Lane v. Calhoun-Liberty County Hosp. Ass'n, Inc., N.D.Fla.1994, 846 F.Supp. 1543.

Doctor's practice to treat emergency room patient only for referred problems due to fact that patient was under active treatment of another physician did not constitute characteristic peculiar to patient so as to provide basis for discriminatory motive under Emergency Medical Treatment and Active Labor Act (EMTALA); fact that patient was under care of another physician was not characteristic peculiar to patient and neither was fact that patient came to emergency room complaining of only certain things, for such qualities were distinctly different from those peculiar patient characteristics, such as age, race, sex,
national origin, financial or insurance condition, social status or politics which may be basis for claim of improper motive under EMTALA. Hines v. Adair County Public Hosp. Dist. Corp., W.D.Ky.1993, 827 F.Supp. 426.


Liability for death of infant shortly after he had been transferred from one hospital to another, where family pediatrician would be in attendance, could not be based on federal statute providing that hospitals that have emergency departments and participate in Medicare program must provide screening examinations for all patients and treatment to those patients with emergency medical conditions, since purpose of statute was to combat problem of "patient dumping," and it was not alleged that parents' financial condition or lack of health insurance contributed to decision of physician at first hospital not to treat their son. Nichols v. Estabrook, D.N.H.1989, 741 F.Supp. 1030, reconsideration denied 777 F.Supp. 1159.

Emergency room patient who was examined and released while still suffering chest pains failed to establish that she was turned away from hospital for economic reasons, as was required to state claim under federal antipatient dumping statute; patient's real complaint sounded in medical malpractice, for which medical malpractice action was proper remedy. Evitt v. University Heights Hosp., S.D.Ind.1989, 727 F.Supp. 495.

"comes to the emergency department" and requests treatment, so as to prevent hospital from diverting any patient en route to emergency room in ambulance, even in ambulance not owned by hospital, except for valid treatment-related reasons, was reasonable and in keeping with purpose of EMTALA, and barred hospital from diverting ambulance en route to hospital with patient who was experiencing heart attack, unless hospital was in diversionary status. Arrington v. Wong, C.A.9 (Hawai'i) 2001, 237 F.3d 1066. Health © 2010 Thomson Reuters. No Claim to Orig. US Gov. Works. B-81

Statutory precondition for triggering hospital's duties under Emergency Medical Treatment and Active Labor Act (EMTALA) are conjunctive, requiring both that individual come to emergency department, and that request for examination or treatment be made. Miller v. Medical Center of Southwest Louisiana, C.A.5 (La.) 1994, 22 F.3d 626.

Injured, uninsured child did not "come to" emergency department at hospital which allegedly instructed doctor over telephone not to send child to hospital, precluding imposition of liability on hospital under Emergency Medical Treatment and Active Labor Act (EMTALA). Miller v. Medical Center of Southwest Louisiana, C.A.5 (La.) 1994, 22 F.3d 626.

For purposes of cause of action for negligence under COBRA, which requires hospitals receiving federal funds to provide appropriate emergency screening examinations, hospital-operated telemetry system is distinct from hospital's emergency room so that patient sent to different hospital under direction from telemetry system never "comes to" the hospital operating the system. Johnson v. University of Chicago Hospitals, C.A.7 (Ill.) 1992, 982 F.2d 230, rehearing denied, as amended, on remand.


Emergency room physician's radio communication with ambulance personnel that advised them to take patient in severe respiratory distress to more distant hospital was not actionable under Emergency Medical Treatment and Active Labor Act (EMTALA) as patient did not "come to" emergency room before being discharged or transferred as
42 U.S.C.A. § 1395dd, 42 USCA § 1395dd


Emergency Medical Treatment and Active Labor Act (EMTALA), or Anti-Dumping Act, did not apply to child who was born at hospital with emergency medical condition, even though for obvious reasons, child did not "come to the hospital" seeking treatment for this condition. Lopez-Soto v. Hawayek, D.Puerto Rico 1997, 988 F.Supp. 41, supplemented 20 F.Supp.2d 279, reversed 175 F.3d 170.

35. Emergency unit

Fact that patient was directly admitted to hospital by his private physician for prearranged surgical procedure and not through hospital's emergency room did not require dismissal of claim under Emergency Medical Treatment and Active Labor Act (EMTALA). Reynolds v. Mercy Hosp., W.D.N.Y.1994, 861 F.Supp. 214.

36. Financial status of patient


Allegations that non-profit corporations that provided medical services to uninsured patients first determined their ability to pay for such care, and required them to sign form contracts agreeing to pay in full for their care, did not state a claim for violation of the Emergency Medical Treatment and Active Labor Act (EMTALA), given that EMTALA does not forbid providers of medical services from inquiring into patients' ability to pay for treatment, so long as their inquiry does not delay screening or treatment, and EMTALA did not provide for recovery for economic injury. Amato v. UPMC, W.D.Pa.2005, 371 F.Supp.2d 752.

Scope of Emergency Medical Treatment and Active Labor Act (EMTALA), which is statutory response to reports that hospital emergency rooms were refusing to accept or treat patients arriving at their emergency departments who lacked medical insurance, extends to all individuals who present themselves at a covered hospital, not just to the indigent and uninsured. Torres Otero v. Hospital General Menonita, D.Puerto Rico 2000, 115 F.Supp.2d 253.

Stroke victim was not required to allege that he was discharged from hospital for economic reasons in order to state claim for relief under Emergency Medical Treatment and Active Labor Act (EMTALA); rather, allegation that hospital discharged him without first stabilizing his condition was sufficient to state claim under EMTALA. Cooper v. Gulf Breeze Hosp., Inc., N.D.Fla.1993, 839 F.Supp. 1538.

To come within protection of Federal Emergency Medical Treatment and Active Labor Act, plaintiff need not allege he was indigent or uninsured, nor need he allege that economic, race, ethnicity or any other reason motivated hospital to treat him inappropriately. Ruiz v. Kepler, D.N.M.1993, 832 F.Supp. 1444.

Plaintiff bringing action under Emergency Medical Treatment and Active Labor Act (EMTALA) need not allege indigence of patient at outset of complaint; plain reading of EMTALA indicates that statutory language requiring participating hospital to determine whether "an emergency medical condition exists for any individual" extends protection to all individuals who present at such hospitals. Ballachino v. Anders, W.D.N.Y.1993, 811 F.Supp. 121.

Comprehensive Omnibus Budget Reconciliation Act (COBRA) provision that prohibits patient dumping by hospitals that receive Medicare funds is not limited to situations in which patient was refused treatment for economic reasons; rather, COBRA plainly states that it applies to "any individual" who requests emergency room treatment. Jones v. Wake County Hosp. System, Inc., E.D.N.C.1991, 786 F.Supp. 538.

Emergency Medical Treatment and Active Labor Act extends protection to "any individual" who seeks emergency room assistance, and does not apply only to those who are indigent or not covered by insurance. Urban v. King, D.Kan.1992, 783 F.Supp. 560.

The mother of a child who allegedly received treatment at a hospital's emergency room and was discharged without her condition having been stabilized stated a cause of action against hospital under the Federal Emergency Medical Treatment and Active Labor Act for "patient dumping"; statute did not mention an indigency, inability to pay, or hospital's motive as prerequisites to coverage and did not only apply to outright refusals to treat. Deberry

Hospital's failure to act for at least 90 minutes after child was brought into emergency room after choking on peanut did not violate provision of Patient Anti-Dumping Act prohibiting hospital from delaying appropriate medical screening examination in order to inquire about individual's method of payment or insurance status; there was no evidence to indicate that medical screening examination was delayed due to lack of insurance since medical records indicated that mother was not questioned about insurance until after triage nurse had screened child. Anadumaka By and Through Anadumaka v. Edgewater Operating Co., N.D.Ill.1993, 823 F.Supp. 507.

Emergency Medical Treatment and Active Labor Act (EMTALA) does not give patients private cause of action against doctors for failure to provide appropriate medical screening examination, failure to stabilize patient's emergency medical condition, or transfer of patient without first providing stabilizing treatment. Baber v. Hospital Corp. of America, C.A.4 (W.Va.) 1992, 977 F.2d 872.

Emergency Medical Treatment and Active Labor Act (EMTALA) provided private right of action for retaliation that would permit emergency assessment worker's claim against hospital employer as whistleblower for alleged retaliatory termination because of his reporting of EMTALA violations by hospital that refused to accept suicidal unfunded patient, including claims for financial losses and damages for humiliation, pain and suffering, and embarrassment. Fotia v. Palmetto Behavioral Health, D.S.C.2004, 317 F.Supp.2d 638.

Emergency Medical Treatment and Active Labor Act (EMTALA) does not create a general federal cause of action for medical malpractice, nor is it a substitute for state-law malpractice actions, and thus, EMTALA does not provide a private cause of action against physicians or physicians' medical corporations.


The Emergency Medical Treatment and Active Labor Act (EMTALA) does not provide for a private cause of action against individual physicians nor does it provide a cause of action against physicians' medical corporations. Marrero v. Hospital Hermanos Melendez, Inc., D.Puerto Rico 2003, 253 F.Supp.2d 179.

Husband and daughter of patient who allegedly received inadequate screening in violation of the Emergency Medical Treatment and Active Labor Act (EMTALA) could not bring action of their own under EMTALA. Malave Sastre v. Hospital Doctor's Center, Inc., D.Puerto Rico 2000, 93 F.Supp.2d 105.

While coverage of Emergency Medical Treatment and Active Labor Act (EMTALA) does not limit its coverage to persons without economic resources for emergency care, neither does it provide private cause of action against the hospital and physician for misdiagnosis or improper treatment, which are areas traditionally governed by state malpractice law. Torres Nieves v. Hospital Metropolitano, D.Puerto Rico 1998, 998 F.Supp. 127.

By enacting Emergency Medical Treatment and Active Labor Act (EMTALA), Congress intended to create federal cause of action that draws on substantive state law in manner similar to Federal Tort Claims Act (FTCA), which allows federal court jurisdiction over tort claims against United States government that are defined by reference to state law. Vazquez Morales v. Estado Libre Asociado de Puerto Rico, D. Puerto Rico 1997, 967 F.Supp. 42.

Section of Social Security Act permitting civil money penalty of not more than $50,000 against participating hospital that negligently violates requirement of Emergency Medical Treatment and Active Labor Act (EMTALA) is civil penalty provision to be enforced by United States Government or one of its agencies, not by private plaintiff. Holcomb v. Monahan, M.D.Ala.1992, 807 F.Supp. 1526.

Emergency Medical Treatment and Active Labor Act does not provide private remedy for individuals against physician or physician group for violation of the Act, although the Act provides express private


39. Administrative right of action

Antidumping act did not create private cause of action to terminate hospital's Medicare provider agreement for mother of emergency room patient whose spinal meningitis was allegedly not diagnosed because of hospital's failure to provide appropriate medical screening; sanction of terminating violating hospital's provider agreement was to be imposed at initiative of Secretary of Health and Human Services. *Deberry v. Sherman Hosp. Ass'n*, N.D.Ill.1991, 775 F.Supp. 1159.

40. Persons entitled to maintain action


Emergency Medical Treatment and Active Labor Act (EMTALA) did not require determination that wrongful discharge which provided basis for plaintiff's EMTALA violation claim was "personal injury claim" under relevant state law, but only required determination that plaintiff suffered personal harm as direct result of participating hospital's EMTALA violation, and plaintiff employee's claim of retaliatory discharge by employer hospital accordingly provided standing and federal subject matter jurisdiction for suit. *Fotia v. Palmetto Behavioral Health*, D.S.C.2004, 317 F.Supp.2d 638. Health © 266

Deceased patient's widow and siblings had authority to pursue a claim under the Emergency Medical Treatment and Active Labor Act (EMTALA) against a hospital, despite claim that the words "individual" and "direct," in the EMTALA section providing for a cause of action to any individual that suffers direct harm, denoted that only the patient could make a claim under EMTALA; Puerto Rico law provided that the heirs of a person who died through another's negligence had claims both for their own suffering and the suffering of the decedent, and Puerto Rico law also allowed a cause of action to immediate family relatives of an individual, who suffered as a result of another's failure to conform to a duty. *Marrero v. Hospital Hermanos Melendez, Inc., D.Puerto Rico 2003, 253 F.Supp.2d 179*. Health © 658; Health © 810

Parent could not bring action in her individual capacity against hospital under Emergency Medical Treatment and Active Labor Act (EMTALA) for violation related to her daughter's medical condition. *Zeigler v. Elmore County Health Care Authority, M.D.Ala.1999, 56 F.Supp.2d 1324*. Health © 658


Indigent adolescent who, while in labor, was directed by hospital to travel to another hospital 200 miles away to deliver, in violation of Anti-Dumping Act, had standing to maintain claim for permanent injunctive relief, even though she was no longer pregnant; evidence demonstrated pattern of either negligent or deliberate flouting by hospital of its obligations under Act. *Owens v. Nacogdoches County Hosp. Dist., E.D.Tex.1990, 741 F.Supp. 1269*.

41. Liable parties

"Patient-dumping" statute applies only to physicians connected with emergency room or other portion of hospital, and not to physicians in private clinic. *King v. Ahrens, C.A.8 (Ark.) 1994, 16 F.3d 265*, rehearing denied.

Hospital could be held directly accountable under Emergency Medical Treatment and Active Labor Act (EMTALA) for actions of surgical resident who allegedly discharged patient before her condition had been stabilized. *Roberts v. Galen of Virginia, Inc., W.D.Ky.2000, 112 F.Supp.2d 638*. Health © 658

Since there is no private cause of action against physicians under Emergency Medical Treatment and Active Labor Act (EMTALA), it follows that there is no private cause of action against their medical corporations. Gerber v. Northwest Hosp. Center, Inc., D.Md.1996, 943 F.Supp. 571.

Emergency Medical Treatment and Active Labor Act (EMTALA), which prohibits transfer or release of emergency room patient before medical condition has stabilized, provides no private cause of action for recovery of damages against physician, but is instead limited to actions against participating hospitals. Deron v. Wilkins, S.D.Miss.1995, 879 F.Supp. 603.


Emergency Medical Treatment and Active Labor Act (EMTALA) did not create private cause of action against individual physicians under plain statutory language indicating that civil action may be brought against a hospital. Howe v. Hull, N.D.Ohio 1994, 874 F.Supp. 779.


Emergency Medical Treatment and Active Labor Act (EMTALA) does not provide private right of action against individual physician; if Congress had intended to sanction not only hospitals for violations but also physicians, it would have done so. Kaufman v. Cserny, S.D.III.1994, 856 F.Supp. 1307.


Person injured by "patient dumping" violating Emergency Medical Treatment and Active Labor Act (EMTALA) may bring private action against participating hospital for civil damages, but has no similar cause of action for recovery of damages from physician. Helton v. Phelps County Regional Medical Center, E.D.Mo.1993, 817 F.Supp. 789.

No private right of action exists against individual physicians under Emergency Medical Treatment and Active Labor (EMTALA); EMTALA's enforcement provision is explicitly limited to actions against participating hospital. Ballachino v. Anders, W.D.N.Y.1993, 811 F.Supp. 121.

Comprehensive Omnibus Budget Reconciliation Act (COBRA) provision that prohibits patient dumping by hospitals that receive Medicare funds does not permit private cause of action against individual physicians; Congress specifically authorized civil monetary penalties against both hospitals and physicians, but permitted private cause of action only against hospitals. Jones v. Wake County Hosp. System, Inc., E.D.N.C.1991, 786 F.Supp. 538.


42. Jurisdiction--Generally

Personal representative of deceased patient's estate originally asserted nonfrivolous federal question claim under Federal Patient Anti-Dumping Act against both private physician and medical professional corporation and hospital, where applicability of Act to private physicians and medical professional corporations was unsettled when suit was filed. Palmer v. Hospital Authority of Randolph County, C.A.11 (Ga.) 1994, 22 F.3d 1559.


District Court had pendent party jurisdiction over patient's state claim against physician, in patient's action against hospital, physician, and others pursuant to Emergency Medical Treatment and Active Labor Act (EMTALA) for failure to screen, stabilize, and transfer, although physician could not be liable under EMTALA, where state claim against physician arose out of same set of facts as EMTALA claim. Alvarez Torres v. Ryder Memorial Hosp., Inc., D.Puerto Rico 2004, 308 F.Supp.2d 38. Federal Courts 15

District court had subject matter jurisdiction over action by patient's administratrix alleging that

Violation of Emergency Medical Treatment and Active Labor Act, which was enacted as part of Consolidated Omnibus Budget Reconciliation Act of 1986, may be pursued in federal forum, although Act does not specifically provide for remedy in United States district courts.  Sorrells v. Babcock, N.D.Ill. 1990, 733 F.Supp. 1189.

Federal district court had jurisdiction over patient's action against hospital for violation of Emergency Medical Treatment and Active Labor Act, in which patient alleged that she was discharged by hospital before her condition had been stabilized.  Bryant v. Riddle Memorial Hosp., E.D.Pa. 1988, 689 F.Supp. 490.

43. ---- Supplemental, jurisdiction

District court had authority to exercise supplemental jurisdiction over Georgia state-law claims of personal representative of deceased patients' estates against Georgia physician and hospital based on nonfrivolous Federal Patient Anti-Dumping Act claims against both parties that arose from two occasions when patient presented herself to physician and hospital and allegedly received either mistreatment or no treatment, since Georgia state-law claims all arose from same two events, and involved same witnesses, same evidence, and determination of same, or very similar, facts.  Palmer v. Hospital Authority of Randolph County, C.A.11 (Ga.) 1994, 22 F.3d 1559.

Federal claim under Emergency Medical Treatment and Active Labor Act (EMTALA) was fundamentally different and not part of same case or controversy as state law claims, and, consequently, court could not exercise supplemental jurisdiction over state law claims, where issue central to EMTALA claim was whether healthcare providers provided disparate medical treatment based upon patients' financial resources or insurance status and state law claims were directed to providers' billing and collection practices, and question of whether those practices violated obligations arising from grant of tax exemptions, which was based upon novel theory that grant of state tax exemptions obligated providers to provide affordable health care to uninsured patients.  Ferguson v. Centura Health Corp., 2004, 358 F.Supp.2d 1014, Health 801

44. ---- Ancillary, jurisdiction

In action brought by former patient against emergency room physician for violation of Emergency Treatment and Active Labor Act, which was enacted as part of Consolidated Omnibus Budget Reconciliation Act of 1986, district court would exercise ancillary jurisdiction over patient's pendant state law claim for medical malpractice, as both claims arose out of "common nucleus of operative fact."  Sorrells v. Babcock, N.D.Ill. 1990, 733 F.Supp. 1189.

45. State arbitration procedures

Plaintiff seeking relief under the Emergency Medical Treatment and Active Labor Act (EMTALA) for hospital's failure to adequately screen or treat patient for emergency medical condition need not first pursue arbitration required by Maryland Malpractice Act; Maryland Malpractice Act encompasses only claims for breach of relevant standard of care, and claim under EMTALA does not require any allegation of breach of standard of care.  Brooks v. Maryland General Hosp., Inc., C.A.4 (Md.) 1993, 996 F.2d 708.

46. Removal

Co-administrators of estate were not required to prove that hospital and others violated the Emergency Medical Treatment and Active Labor Act (EMTALA) in order to recover on state law medical negligence claim so as to support removal, nor did their state law claim require resolution of another substantial question of federal law, where they did not allege a claim under the EMTALA and, instead, were using hospitals' alleged violation of EMTALA to support their state law medical negligence claims.  Sercye-McCollum v. Ravenswood Hosp. Medical Center, N.D.Ill. 2001, 140 F.Supp.2d 944.  Removal Of Cases 25(1)

No "substantial federal question" was presented by patient's estate's claim that defendant physician committed medical malpractice by "dumping" patient, who died shortly after being discharged from emergency room, and thus, action was not removable to federal court, and was correctly remanded; despite physician's claim that action arose under Emergency
Medical Treatment and Active Labor Act (EMTALA), no private action is available against individual physician for violation of EMTALA, and estate did not name hospital as defendant. Patterson v. Hamrick, E.D.La.1995, 889 F.Supp. 913.

47. Peer review

Hospital accused of violating Emergency Medical Treatment and Active Labor Act's (EMTALA) reverse-dumping provisions was entitled to review by peer review organization (PRO) to assess whether patient which hospital refused to accept had emergency medical condition which had not been stabilized. St. Anthony Hosp. v. U.S. Dept. of Health and Human Services, C.A.10 2002, 309 F.3d 680.

48. Pleadings

Court of Appeals would not consider issue of whether patient who brought action against hospital for alleged violation of Emergency Medical Treatment and Active Labor Act (EMTALA), also known as Patient Anti-Dumping Act, should have been allowed to amend her complaint by dropping her allegation that hospital failed properly to determine whether emergency condition existed, since issue was not raised until patient's reply brief, and amendment would not have precluded dismissal for failure to state claim. James v. Sunrise Hosp., C.A.9 (Nev.) 1996, 86 F.3d 885.

Complaint failed to state claim against hospital under Emergency Medical Treatment and Active Labor Act (EMTALA); claim was not that patient was given shoddy treatment or no treatment at all because he was different from any other patient, but rather, that doctor made a mistake in diagnosis of patient's leg condition, and inclusion of allegation that patient was treated in a disparate manner did not transform what was essentially a claim of medical malpractice into a claim within the scope of the EMTALA. Lane v. Wellmont Health System, W.D.Va.1999, 46 F.Supp.2d 477.

Husband of deceased patient failed to allege that hospital and physician failed to apply its emergency patient screening procedures, as required to maintain cause of action against them pursuant to Emergency Medical Treatment and Active Labor Act (EMTALA); husband sought to present case to jury through evidence of malpractice, based upon what physician should have inferred from patient's respiratory symptoms, and failure of attending nurse to recheck patient's vital signs was not EMTALA violation absent allegations that initial readings were false. Tank v. Chronister, D.Kan.1996, 941 F.Supp. 969.

Patient satisfied pleading requirements of Federal Emergency Medical Treatment and Active Labor Act by alleging that he went to hospital's emergency room with emergency medical condition, and that hospital either did not adequately screen him to determine whether he had emergency medical condition, or discharged him before emergency condition was stabilized. Ruiz v. Kepler, D.N.M.1993, 832 F.Supp. 1444.

Patient's representative stated claim against hospital under Emergency Medical Treatment and Active Labor Act (EMTALA) where complaint alleged that patient presented at hospital with complaints of chest pain and repeated episodes of loss of consciousness, that hospital was "participating hospital" according to its provider agreement, and that physicians negligently failed to provide appropriate medical screening examination and failed to determine whether or not emergency medical condition existed for patient. Ballachino v. Anders, W.D.N.Y.1993, 811 F.Supp. 121.


Indigent patient stated cause of action for alleged denial of stabilizing treatment under subsec. (6)(1)(A) of this section against county hospital physicians and county hospital to which she was transferred after she reported to emergency room of private hospital with complaints of premature labor pains. Thompson v. St. Anne's Hosp., N.D.Ill.1989, 716 F.Supp. 8.

49. Damages--Generally

Claim against hospital under federal Emergency Medical Treatment and Active Labor Act (EMTALA) based on alleged disparate medical screening constituted "malpractice claim" under Virginia Medical Malpractice Act, and was subject to latter Act's damages cap, notwithstanding that EMTALA referred to claim for personal injury rather than specifically to medical malpractice claims.
Virginia $1 million statutory cap on medical malpractice damages barred patient who had recovered $1 million in damages from hospital in action under federal Emergency Medical Treatment and Active Labor Act (EMTALA) from recovering additional damages from professional corporation under contract with hospital and its physician for injuries arising out of same emergency room visit; by its plain language, statute precludes patient from recovering more than $1 million from injuries arising from one malpractice event, and such principle holds whether patient sues one defendant or many, whether she files one action or separate ones, or whether she proceeds under more than one legal theory. Power v. Alexandria Physicians Group, Ltd., E.D.Va.1995, 887 F.Supp. 845, affirmed 91 F.3d 132, certiorari denied 117 S.Ct. 514, 519 U.S. 1010, 136 L.Ed.2d 403.


Provision in Emergency Medical Treatment and Active Labor Act (EMTALA) allowing injured party to obtain those damages available for personal injury under law of state in which hospital is located does not incorporate Florida medical malpractice law. Cooper v. Gulf Breeze Hosp., Inc., N.D.Fla.1993, 839 F.Supp. 1538.

Individual seeking recovery under Emergency Medical Treatment and Active Labor Act (EMTALA) may only recover those state law personal injury damages that are available for personal harm that plaintiff himself or herself has suffered. Griffith v. Mt. Carmel Medical Center, D.Kan.1993, 826 F.Supp. 382.

Damages recoverable by plaintiff in federal "patient dumping" action against participating hospital under the Emergency Medical Treatment and Active Labor Act (EMTALA) were not limited by the Virginia medical malpractice cap; EMTALA and the malpractice cap had different objectives. Power v. Arlington Hosp., E.D.Va.1992, 800 F.Supp. 1384, affirmed in part, reversed in part 42 F.3d 851.

Damages awarded for infant's past medical expenses had to be included in her own damage award for purposes of Virginia law limiting recovery in medical malpractice actions to $1 million per patient, inasmuch as mother's claim for child's medical and related expenses was derivative of child's action. Lee v. Adrales, W.D.Va.1991, 778 F.Supp. 904.

50 ---- State cap, damages

Certification of question to Massachusetts state court, as to whether Massachusetts statute which limited amount of tort damages that could be awarded against charitable organization should have been applied to federal Emergency Medical Treatment and Labor Act (EMTALA), was not warranted, since it was reasonably clear how state court would have decided matter; state and federal precedent supported position that substantive quality of EMTALA civil action sounded in tort and Congress clearly did not intend for EMTALA to preempt any state law or local requirement, there was long delay in bringing question of certification to court's attention, and issue was raised only after court ruled against proponent of motion. Stewart v. Milford-Whitinsville Hosp., D.Mass.2004, 349 F.Supp.2d 68. Federal Courts 392

Emergency Medical Treatment and Active Labor Act (EMTALA) limited damages that South Carolina emergency assessment worker allegedly terminated in retaliation for reporting violation of EMTALA could recover to those damages available in personal injury claims in South Carolina, but did not require court to "convert" EMTALA claim into analogous state law claim and limit recovery of damages to those recoverable in state law action. Fotia v. Palmetto Behavioral Health, D.S.C.2004, 317 F.Supp.2d 638. Health 266

Patient's widow could maintain claims under both Maine's Wrongful Death Act and federal Emergency Medical Treatment and Liability Act (EMTALA), as alternative bases for holding hospital and physician's liable for patient's death, but damages would be limited to those recoverable under wrongful death statute. Feighery v. York Hosp., D.Me.1999, 38 F.Supp.2d 142. Election Of Remedies 2
Provision of federal Emergency Medical Treatment and Active Labor Act (EMTALA), permitting plaintiff to obtain those damages for personal injury available under the law of state in which defendant hospital is located, permits the application of state-law damages caps. Jackson v. East Bay Hosp., N.D.Cal.1997, 980 F.Supp. 1341.

For purposes of Virginia statute imposing $1 million statutory cap on any one patient's medical malpractice recovery, mother and her newborn child who sued hospital alleging negligence in connection with premature birth were separate patients, who were each entitled to recover maximum of $1 million. Lee by Wetzel v. Alleghany Regional Hosp. Corp., W.D.Va.1991, 778 F.Supp. 900.

51. --- Set off, damages

Physician who was found liable for medical malpractice to mother and infant daughter was entitled to set-off from settlement amounts mother and daughter received from hospital, but not for separate amount paid by hospital to father in settlement of his claim under Federal Consolidated Omnibus Budget Reconciliation Act. Lee v. Adrales, W.D.Va.1991, 778 F.Supp. 904.

52. Injunction

Broad injunction sought by patient who claimed that she had been dumped was not "appropriate" equitable relief, within meaning of Emergency Medical Treatment and Active Labor Act (EMTALA); if court were to issue injunction requiring hospital to comply with the law as to all patients, present and future, court might well be involved in judging, on a regular basis, whether hospital was following the standards of EMTALA. Hart v. Riverside Hosp., Inc., E.D.Va.1995, 899 F.Supp. 264.

Patient's administratrix could seek injunctive remedy under Comprehensive Omnibus Budget Reconciliation Act (COBRA) provision that prohibits patient dumping by hospitals that receive Medicare funds, even though patient died; if patient had brought suit during his lifetime, he would have been free to seek injunction banning future COBRA violations, and, if administratrix could prove deliberate violations by hospital, she and her children and others in community would face genuine threat to their well-being, absent injunction. Jones v. Wake County Hosp. System, Inc., E.D.N.C.1991, 786 F.Supp. 538.

53. Limitations

Claim brought by mother of mentally retarded patient, as committee for patient, against hospital, alleging violation of Emergency Medical Treatment and Active Labor Act, which was filed more than two years after date of alleged violation, was time barred, and Act's statute of limitations was not tolled from date of violation until mother was appointed committee for patient on account of patient's infancy and incompetency. Vogel v. Linde, C.A.4 (Va.) 1994, 23 F.3d 78.

Timely filing of Emergency Medical Treatment and Active Labor Act (EMTALA) claim in state court did not toll two-year limitations period for filing that claim in federal court, although claim was pending in state court when federal claim was filed. Salkases v. Hospital San Pablo Inc., D.Puerto Rico 2005, 371 F.Supp.2d 28. Limitation Of Actions 105(2)

Plaintiff's receipt of expert report in pending state proceeding was not sufficient basis to equitably toll two year statute of limitations governing Emergency Treatment and Active Labor Act (EMTALA) claim, even assuming equitable tolling was available, since plaintiff accompanied patient at time alleged violation occurred and was privy to what transpired thereat. Monrouzeau v. Asociacion del Maestro, D.Puerto Rico 2005, 354 F.Supp.2d 115. Limitation Of Actions 104.5

Because a potential direct conflict exists between Utah's state law pre-litigation claim screening requirements for medical malpractice cases and the Emergency Medical Treatment and Liability Act's (EMTALA) statute of limitations, EMTALA preempts state law on this point; as a result, Utah state pre-litigation screening requirements are not incorporated into EMTALA and do not toll EMTALA's two-year limitations period. Merce v. Greenwood, D.Utah 2004, 348 F.Supp.2d 1271. Limitation Of Actions 105(1); States 18.15

Two year statute of limitations for claims under Emergency Medical Treatment and Active Labor Act (EMTALA) is not tolled by a plaintiff's status as a minor. Bowden ex rel. Bowden v. Wal-Mart Stores, Inc., M.D.Ala.2000, 124 F.Supp.2d 1228. Limitation Of Actions 72(1)

Emergency Medical Treatment and Active Labor

54. Immunity


University of Puerto Rico was entitled to Eleventh Amendment immunity from Emergency Medical Treatment and Active Labor Act (EMTALA) suit filed in federal court; Congress did not expressly abrogate Commonwealth's immunity when it enacted EMTALA, and Commonwealth did not waive its sovereign immunity to be sued in federal court. Lebron v. Ashford Presbyterian Community Hosp., D.Puerto Rico 1997, 975 F.Supp. 407.

Eleventh Amendment immunity operated to bar claim asserted under Emergency Medical Treatment and Active Labor Act (EMTALA) against Commonwealth of Puerto Rico, which was based on actions of hospital owned by Commonwealth; EMTALA does not evince unmistakably clear intent to abrogate Eleventh Amendment immunity of States, and even had Congress so intended, it may not abrogate Eleventh Amendment immunity when exercising powers under Article I. Vazquez Morales v. Estado Libre Asociado de Puerto Rico, D.Puerto Rico 1997, 967 F.Supp. 42.

Congress did not abrogate Commonwealth's immunity against suit in federal court in Emergency Medical Treatment and Active Labor Act (EMTALA); Act's general authorization for federal suit was not kind of unequivocal statutory language sufficient to abrogate the Eleventh Amendment. Perez-Bourdon v. Com. of Puerto Rico, D.Puerto Rico 1997, 951 F.Supp. 22.

42 U.S.C.A. § 1395dd, 42 USCA § 1395dd

Current through P.L. 109-127 approved 12-07-05


END OF DOCUMENT
42 U.S.C.A. § 3027, 42 USCA § 3027

Effective: November 13, 2000

United States Code Annotated Currentness
Title 42. The Public Health and Welfare
Chapter 35. Programs for Older Americans (Refs & Annos)
  ▼ Subchapter III. Grants for State and Community Programs on Aging (Refs & Annos)
  ▼ Part A. General Provisions (Refs & Annos)

§ 3027. State plans

(a) Criteria for eligibility; contents

Except as provided in the succeeding sentence and section 3029(a) of this title, each State, in order to be eligible for grants from its allotment under this subchapter for any fiscal year, shall submit to the Assistant Secretary a State plan for a two-, three-, or four-year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe. If the Assistant Secretary determines, in the discretion of the Assistant Secretary, that a State failed in 2 successive years to comply with the requirements under this subchapter, then the State shall submit to the Assistant Secretary a State plan for a 1-year period that meets such criteria, for subsequent years until the Assistant Secretary determines that the State is in compliance with such requirements. Each such plan shall comply with all of the following requirements:

(1) The plan shall--

(A) require each area agency on aging designated under section 3025(a)(2)(A) of this title to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 3026 of this title; and

(B) be based on such area plans.

(2) The plan shall provide that the State agency will--

(A) evaluate, using uniform procedures described in section 3012(a)(29) of this title, the need for supportive services (including legal assistance pursuant to subsection (a)(11) of this section, information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) develop a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) that have the capacity and actually meet such need; and

(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B of this subchapter that will be expended (in the absence of a waiver under section 3026(b) or 3030c-3 of this title) by such area agency on aging to provide each of the categories of services specified in section 3026(a)(2) of this title.

(3) The plan shall--

(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 3025(d) of this title (concerning intrastate distribution of funds); and

(B) with respect to services for older individuals residing in rural areas--

(i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000;

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this subchapter and subchapter XI of this chapter, including evaluations of the effectiveness of services provided to individuals...
with greatest economic need, greatest social need, or disabilities, with particular attention to low-income minority individuals and older individuals residing in rural areas.

(5) The plan shall provide that the State agency will--

(A) afford an opportunity for a hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this subchapter, to any provider of (or applicant to provide) services;

(B) issue guidelines applicable to grievance procedures required by section 3026(a)(10) of this title; and

(C) afford an opportunity for a public hearing, upon request, by any area agency on aging, by any provider of (or applicant to provide) services, or by any recipient of services under this subchapter regarding any waiver request, including those under section 3030c-3 of this title.

(6) The plan shall provide that the State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this subchapter to the State, including any such funds paid to the recipients of a grant or contract.

(B) The plan shall provide assurances that--

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this chapter;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this chapter; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this chapter.

(8)(A) The plan shall provide that no supportive services, nutrition services, or in-home services will be directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 3058g of this title and this subchapter, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this subchapter for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under subchapter XI of this chapter for fiscal year 2000.

(10) The plan shall provide assurances that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11) The plan shall provide that with respect to legal assistance--

(A) the plan contains assurances that area agencies on aging will (i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance; (ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific regulations promulgated under the Legal Services Corporation Act [42 U.S.C.A. § 2996 et seq.] (other than restrictions and regulations governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and (iii) attempt to involve the private bar in legal assistance activities authorized under this subchapter, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis;

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this subchapter on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services;

(C) the State agency will provide for the coordination of the furnishing of legal assistance to older individuals within the State, and provide advice and technical assistance in the provision of legal assistance to older individuals within the State and support the furnishing of training and technical assistance for legal assistance for older individuals;

(D) the plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this chapter and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; and

(E) the plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals--

(A) the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--

(i) public education to identify and prevent abuse of older individuals;

(ii) receipt of reports of abuse of older individuals;

(iii) active participation of older individuals participating in programs under this chapter through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

(iv) referral of complaints to law enforcement or public protective service agencies where appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in this paragraph by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.
42 U.S.C.A. § 3027, 42 USCA § 3027

(14) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area--

(A) to utilize, in the delivery of outreach services under section 3026(a)(2)(A) of this title, the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this chapter; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(15) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared--

(A) identify the number of low-income minority older individuals in the State; and

(B) describe the methods used to satisfy the service needs of such minority older individuals.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will--

(A) identify individuals eligible for assistance under this chapter, with special emphasis on--

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas); 

(iii) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 3026(a)(7) of this title, for older individuals who--

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 3058d(a) of this title.

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance
to minority providers of services.

(21) The plan shall--

(A) provide an assurance that the State agency will coordinate programs under this subchapter and programs under subchapter X of this chapter, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this subchapter, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 3026(a)(8) of this title.

(23) The plan shall provide assurances that demonstrable efforts will be made--

(A) to coordinate services provided under this chapter with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this subchapter, to services under subchapter X of this chapter, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this subchapter.

(26) The plan shall provide assurances that funds received under this subchapter will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this subchapter.

(b) Approval by Assistant Secretary; waiver of requirements

(1) The Assistant Secretary shall approve any State plan which the Assistant Secretary finds fulfills the requirements of subsection (a) of this section, except the Assistant Secretary may not approve such plan unless the Assistant Secretary determines that the formula submitted under section 3025(a)(2)(D) of this title complies with the guidelines in effect under section 3025(a)(2)(C) of this title.

(2) The Assistant Secretary, in approving any State plan under this section, may waive the requirement described in paragraph (3)(B) of subsection (a) of this section if the State agency demonstrates to the Assistant Secretary that the service needs of older individuals residing in rural areas in the State are being met, or that the number of older individuals residing in such rural areas is not sufficient to require the State agency to comply with such requirement.

(c) Notice and hearing prior to disapproval

(1) The Assistant Secretary shall not make a final determination disapproving any State plan, or any modification thereof, or make a final determination that a State is ineligible under section 3025 of this title, without first affording the State reasonable notice and opportunity for a hearing.

(2) Not later than 30 days after such final determination, a State dissatisfied with such final determination may appeal such final determination to the Secretary for review. If the State timely appeals such final determination in accordance with subsection (e)(1) of this section, the Secretary shall dismiss the appeal filed under this paragraph.

(3) If the State is dissatisfied with the decision of the Secretary after review under paragraph (2), the State may appeal such decision not later than 30 days after such decision and in the manner described in subsection (e) of this section. For purposes of appellate review under the preceding sentence, a reference in subsection (e) of this section to the Assistant Secretary shall be deemed to be a reference to the Secretary.

(d) Discontinuance of payments; disbursment of
withdrawn funds to agencies with approved plans; matching funds

Whenever the Assistant Secretary, after reasonable notice and opportunity for a hearing to the State agency, finds that--

(1) the State is not eligible under section 3025 of this title,

(2) the State plan has been so changed that it no longer complies substantially with the provisions of subsection (a) of this section, or

(3) in the administration of the plan there is a failure to comply substantially with any such provision of subsection (a) of this section,

the Assistant Secretary shall notify such State agency that no further payments from its allotments under section 3024 of this title and section 3028 of this title will be made to the State (or, in the Assistant Secretary's discretion, that further payments to the State will be limited to projects under or portions of the State plan not affected by such failure), until the Assistant Secretary is so satisfied that there will no longer be any failure to comply. Until the Assistant Secretary is so satisfied, no further payments shall be made to such State from its allotments under section 3024 of this title and section 3028 of this title (or payments shall be limited to projects under or portions of the State plan not affected by such failure). The Assistant Secretary shall, in accordance with regulations the Assistant Secretary shall prescribe, disburse the funds so withheld directly to any public or nonprofit private organization or agency or political subdivision of such State submitting an approved plan in accordance with the provisions of this section. Any such payment shall be matched in the proportions specified in section 3024 of this title.

(c) Appeal

(1) A State which is dissatisfied with a final action of the Assistant Secretary under subsection (b), (c), or (d) of this section may appeal to the United States court of appeals for the circuit in which the State is located, by filing a petition with such court within 30 days after such final action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Assistant Secretary, or any officer designated by the Assistant Secretary for such purpose. The Assistant Secretary thereupon shall file in the court the record of the proceedings on which the Assistant Secretary's action is based, as provided in section 2112 of Title 28.

(2) Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Assistant Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Assistant Secretary may modify or set aside the Assistant Secretary's order. The findings of the Assistant Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Assistant Secretary to take further evidence, and the Assistant Secretary shall, within 30 days, file in the court the record of those further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Assistant Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of Title 28.

(3) The commencement of proceedings under this subsection shall not, unless so specifically ordered by the court, operate as a stay of the Assistant Secretary's action.

(f) Confidentiality of information relating to legal assistance

Neither a State, nor a State agency, may require any provider of legal assistance under this subchapter to reveal any provider of legal assistance that is protected by the attorney-client privilege.

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports


References in Text

This subchapter, referred to in text, was in the original "this title", meaning Title III of the Older Americans Act of 1965, Pub.L. 89-73, July 14, 1965, 79 Stat. 220 et seq., as amended, which is classified principally to section 3058 et seq. of this title.

Subchapter XI of this chapter, referred to in subsec. (a)(4), (9), was in the original "title VII", meaning Title VII [section 701 et seq.] of the Older Americans Act of 1965, Pub.L. 89-73, July 14, 1965, 79 Stat. 218 et seq., as amended, which is classified generally to subchapter X (section 2996 et seq.) of chapter 34 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 2996 of this title and Tables.

Subchapter X of this chapter, referred to in subsec. (a)(21)(A), (24), was in the original "title VI", meaning Title VI [section 601 et seq.] of the Older Americans Act of 1965, Pub.L. 89-73, July 14, 1965, 79 Stat. 218 et seq., as amended, which is classified to section 3057 et seq. of this title.

Amendments

2000 Amendments. Subsec. (a)(1) to (5). Pub.L. 106-501, § 306(1), rewrote former pars. (1) to (5). Prior to amendment, former pars. (1) to (5) read as follows:

"(1) The plan shall contain assurances that the State plan will be based upon area plans developed by area agencies on aging within the State designated under section 3025(a)(2)(A) of this title and that the State will prepare and distribute a uniform format for use by area agencies on aging in developing area plans under section 3026 of this title.

"(2) The plan shall provide that each area agency on aging designated under section 3025(a)(2)(A) of this title will develop and submit to the State agency for approval an area plan which complies with the provisions of section 3026 of this title.

"(3)(A) The plan shall provide that the State agency will evaluate the need for supportive services (including legal assistance and transportation services), nutrition services, and multipurpose senior centers within the State and determine the extent to which existing public or private programs meet such need. To conduct the evaluation, the State agency shall use the procedures implemented under section 3012(a)(29) of this title.
"(B) The plan shall provide assurances that the State agency will spend in each fiscal year, for services to older individuals residing in rural areas in the State assisted under this subchapter, an amount equal to not less than 105 percent of the amount expended for such services (including amounts expended under subchapter V and subchapter VII of this chapter) in fiscal year 1978.

"(4) The plan shall provide for the use of such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Assistant Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods) as are necessary for the proper and efficient administration of the plan, and, where necessary, provide for the reorganization and reassignment of functions to assure such efficient administration.

"(5) The plan shall provide that the State agency will afford an opportunity for a hearing upon request to any area agency on aging submitting a plan under this subchapter, to any provider of a service under such a plan, or to any applicant to provide a service under such a plan. The State agency shall establish and publish procedures for requesting and conducting such hearing."

Subsec. (a)(7)(C). Pub.L. 106-501, § 306(2), struck out former subpar. (C). Prior to amendment, former subpar. (C) read as follows:

"The plan shall provide assurances that the State agency and each area agency on aging will--

"(i) maintain the integrity and public purpose of services provided, and service providers, under the State plan in all contractual and commercial relationships;

"(ii) disclose to the Assistant Secretary--

"(I) the identity of each nongovernmental entity with which the State agency or area agency on aging has a contract or commercial relationship relating to providing any service to older individuals; and

"(II) the nature of such contract or such relationship;

"(iii) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this chapter by such agency has not resulted and will not result from such contract or such relationship;

"(iv) demonstrate that the quantity or quality of the services to be provided under the State plan will be enhanced as a result of such contract or such relationship; and

"(v) on the request of the Assistant Secretary, for the purpose of monitoring compliance with this chapter (including conducting an audit), disclose all sources and expenditures of funds the State agency and area agency on aging receive or expend to provide services to older individuals."

Subsec. (a)(8), (9). Pub.L. 106-501, § 306(3), rewrote former pars. (8) and (9). Prior to amendment, former pars. (8) and (9) read as follows:

"(8) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out under the State plan, including an evaluation of the effectiveness of the State agency in reaching older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority individuals. In conducting such evaluations and public hearings, the State agency shall solicit the views and experiences of entities that are knowledgeable about the needs and concerns of low-income minority older individuals.

"(9) The plan shall provide for establishing and maintaining information and assistance services in sufficient numbers to assure that all older individuals in the State who are not furnished adequate information and assistance services under section 3026(a)(4) of this title will have reasonably convenient access to such services."

Subsec. (a)(10). Pub.L. 106-501, § 306(4), rewrote former par. (10). Prior to amendment, former par. (10) read as follows:

"The plan shall provide that no supportive services, nutrition services, or in-home services (as defined in section 3030i of this title) will be directly provided by the State agency or an area agency on aging, except where, in the judgment of the State agency, provision of such services by the State agency or an area agency on aging is necessary to assure an adequate supply of such services, or where such
services are directly related to such State or area agency on aging's administrative functions, or where such services of comparable quality can be provided more economically by such State or area agency on aging."

Subsec. (a)(11), (12). Pub.L. 106-501, § 306(5), (6), struck out former pars. (11) and (12), and redesignated former pars. (15) and (16) as pars. (11) and (12). Prior to amendment, former pars. (11) and (12) read as follows:

"(11) The plan shall provide that subject to the requirements of merit employment systems of State and local governments--

"(A) preference shall be given to older individuals; and

"(B) special consideration shall be given to individuals with formal training in the field of aging (including an educational specialty or emphasis in aging and a training degree or certificate in aging) or equivalent professional experience in the field of aging;

"for any staff positions (full time or part time) in State and area agencies for which such individuals qualify.

"(12) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 3058g of this title and this subchapter."

Subsec. (a)(13). Pub.L. 106-501, § 306(5), (8), struck out former par. (13), and redesignated former par. (18) as par. (13). Prior to amendment, former par. (13) read as follows:

"(13) The plan shall provide with respect to nutrition services that--

"(A) each project providing nutrition services will be available to older individuals and to their spouses, and may be made available to handicapped or disabled individuals who have not attained 60 years of age but who reside in housing facilities occupied primarily by older individuals at which congregate nutrition services are provided;

"(B) primary consideration shall be given to the provision of meals in a congregate setting, except that each area agency on aging (i) may award funds made available under this subchapter (other than under section 3023(b)(3) of this title) to organizations for the provision of home delivered meals to older individuals in accordance with the provisions of subpart II of part C of this subchapter, based upon a determination of need made by the recipient of a grant or contract entered into under this subchapter, without requiring that such organizations also provide meals to older individuals in a congregate setting; and (ii) shall, in awarding such funds, select such organizations in a manner which complies with the provisions of subparagraph (H);

"(C)(i) each project will permit recipients of grants or contracts to solicit voluntary contributions for meals furnished in accordance with guidelines established by the Assistant Secretary, taking into consideration the income ranges of eligible individuals in local communities and other sources of income of the recipients of a grant or contract; and

"(ii) such voluntary contributions will be used to increase the number of meals served by the project involved, to facilitate access to such meals, and to provide other supportive services directly related to nutrition services;

"(D) in the case of meals served in a congregate setting, a site for such services and for comprehensive supportive services is furnished in as close proximity to the majority of eligible individuals' residences as feasible, with particular attention upon a multipurpose senior center, a school, a church, or other appropriate community facility, preferably within walking distance where possible, and where appropriate, transportation to such site is furnished;

"(E) each project will establish outreach activities which assure that the maximum number of eligible individuals may have an opportunity to participate;

"(F) each project will establish and administer the nutrition project with the advice of dietitians (or individuals with comparable expertise), persons competent in the field of service in which the nutrition project is being provided, older individuals who will participate in the program, and of persons who are knowledgeable with regard to the needs of older individuals;

"(G) each project will provide special menus,
where feasible and appropriate, to meet the particular dietary needs arising from the health requirements, religious requirements, or ethnic backgrounds of eligible individuals;

"(H) each area agency on aging will give consideration, where feasible, in the furnishing of home delivered meals to the use of organizations which (i) have demonstrated an ability to provide home delivered meals efficiently and reasonably; and (ii) furnish assurances to the area agency on aging that such an organization will maintain efforts to solicit voluntary support and that funds made available under this subchapter to the organization will not be used to supplant funds from non-Federal sources;

"(I) each area agency on aging shall establish procedures that will allow nutrition project administrators the option to offer a meal, on the same basis as meals are provided to participating older individuals, to individuals providing volunteer services during the meal hours, and to individuals with disabilities who reside at home with and accompany older individuals who are eligible under this chapter;

"(J) each nutrition project shall provide nutrition education on at least a semiannual basis to participants in programs described in part C of this subchapter;

"(K) each project shall comply with applicable provisions of State or local laws regarding the safe and sanitary handling of food, equipment, and supplies used in the storage, preparation, service, and delivery of meals to an older individual;

"(L) the State agency will monitor, coordinate, and assist in the planning of nutritional services, with the advice of a dietitian or an individual with comparable expertise; and

"(M) the State agency will--

"(i) develop nonfinancial criteria for eligibility to receive nutrition services under section 3030f of this title; and

"(ii) periodically evaluate recipients of such services to determine whether they continue to meet such criteria."

Subsec. (a)(14). Pub.L. 106-501, § 306(5), (10), struck out former par. (14), and redesignated former par. (20) as par. (14). Prior to amendment, former par. (14) read as follows:

"(14) The plan shall provide, with respect to the acquisition (in fee simple or by lease for 10 years or more), alteration, or renovation of existing facilities (or the construction of new facilities in any area in which there are no suitable structures available, as determined by the State agency, after full consideration of the recommendations made by area agencies on aging, to be a focal point for the delivery of services assisted under this subchapter) to serve as multipurpose senior centers, that--

"(A) the plan contains or is supported by reasonable assurances that (i) for not less than 10 years after acquisition, or not less than 20 years after the completion of construction, the facility will be used for the purpose for which it is to be acquired or constructed, unless for unusual circumstances the Assistant Secretary waives the requirement of this division; (ii) sufficient funds will be available to meet the non-Federal share of the cost of acquisition or construction of the facility; (iii) sufficient funds will be available when acquisition or construction is completed, for effective use of the facility for the purpose for which it is being acquired or constructed; and (iv) the facility will not be used and is not intended to be used for sectarian instruction or as a place for religious worship;

"(B) the plan contains or is supported by reasonable assurances that, in the case of purchase or construction, there are no existing facilities in the community suitable for leasing as a multipurpose senior center;

"(C) the plans and specifications for the facility are in accordance with regulations relating to minimum standards of construction, promulgated with particular emphasis on securing compliance with the requirements of the Act of August 12, 1968, commonly known as the Architectural Barriers Act of 1968 [42 U.S.C.A. § 4151 et seq.];

"(D) the plan contains or is supported by adequate assurance that any laborer or mechanic employed by any contractor or subcontractor in the performance of work on the facility will be paid wages at rates not less than those prevailing for similar work in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C.A. § § 276a-276a-5; commonly known as the Davis-Bacon Act), and the Secretary of Labor shall have, with respect to
the labor standards specified in this subparagraph, the authority and functions set forth in reorganization plan numbered 14 of 1950 (15 F.R. 3176; 64 Stat. 1267), and section 276c of Title 40; and

"(E) the plan contains assurances that the State agency will consult with the Secretary of Housing and Urban Development with respect to the technical adequacy of any proposed alteration or renovation."

Subsec. (a)(15). Pub.L. 106-501, § 306(6), (12), redesignated former pars. (15) and (23) as pars. (11) and (15).

Subsec. (a)(16). Pub.L. 106-501, § 306(6), (12), (13), redesignated former pars. (16) and (24) as pars. (12) and (16), and inserted "and older individuals residing in rural areas" after "low-income minority individuals" wherever appearing in redesignated par. (16).

Subsec. (a)(17). Pub.L. 106-501, § 306(7), (12), (14), struck out former par. (17), redesignated former par. (25) as par. (17), and inserted "to enhance services" before "and develop collaborative programs" in redesignated par. (17). Prior to amendment, former par. (17) read as follows:

"The plan shall provide assurances that the plan contain s assurances that the State agency will consult with the Secretary of Housing and Urban Development with respect to the technical adequacy of any proposed alteration or renovation."

Subsec. (a)(20). Pub.L. 106-501, § 306(10), (17), redesignated former pars. (20) and (32) as pars. (14) and (20), respectively.

Subsec. (a)(21). Pub.L. 106-501, § 306(11), (18), struck out former par. (21) and inserted par. (21). Prior to amendment, former par. (21) read as follows:

"The plan shall provide assurances that the State agency, in carrying out the State Long-Term Care Ombudsman program under subsection (a)(12) of this section, will expend not less than the total amount expended by the agency in fiscal year 1991 in carrying out such a program under this subchapter."

Subsec. (a)(22). Pub.L. 106-501, § 306(11), (19), 801(c)(4)(A), struck out former par. (22), redesignated former par. (36) as par. (22), and substituted "3026(a)(8) of this title" for "3026(a)(20) of this title" in par. (22), as redesignated. Prior to amendment, former par. (22) read as follows:

"The plan shall specify a minimum percentage of the funds received by each area agency on aging for part B of this subchapter that will be expended, in the absence of the waiver granted under section 3026(b)(1) of this title, by such area agency on aging to provide each of the categories of services specified in section 3026(a)(2) of this title."

Subsec. (a)(23) to (25). Pub.L. 106-501, § 306(12), (21), redesignated former pars. (23) to (25), (41), (42) and (44) as pars. (15) to (17), and (23) to (25), respectively.


Subsec. (a)(27) to (29). Pub.L. 106-501, § 306(16), struck out former pars. (27) to (29). Prior to amendment, former pars. (27) to (29) read as follows:

"(27) The plan shall provide assurances of consultation and coordination in planning and provision of in-home services under section 3030h of this title with State and local agencies and private nonprofit organizations which administer and provide services relating to health, social services, rehabilitation, and mental health services.

"(28) The plan shall provide assurances that if the State receives funds appropriated under section 3023(e) of this title, the State agency and area agencies on aging will expend such funds to carry out part E of this subchapter."
"(29) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared, describe the methods used to satisfy the service needs of older individuals who reside in rural areas."


Subsec. (a)(31). Pub.L. 106-501, § 306(16), struck out former par. (31). Prior to amendment, former par. (31) read as follows:

"(A) If 50 percent or more of the area plans in the State provide for an area volunteer services coordinator, as described in section 3026(a)(12) of this title, the State plan shall provide for a State volunteer services coordinator, who shall--

"(i) encourage area agencies on aging to provide for area volunteer services coordinators;

"(ii) coordinate the volunteer services offered between the various area agencies on aging;

"(iii) encourage, organize, and promote the use of older individuals as volunteers to the State;

"(iv) provide technical assistance, which may include training, to area volunteer services coordinators; and

"(v) promote the recognition of the contribution made by volunteers to the programs administered under the State plan.

"(B) If fewer than 50 percent of the area plans in the State provide for an area volunteer services coordinator, the State plan may provide for the State volunteer services coordinator described in subparagraph (A)."


Subsec. (a)(33) to (35). Pub.L. 106-501, § 306(18), struck out former pars. (33) to (35). Prior to amendment, former pars. (33) to (35) read as follows:

"(33) The plan--

"(A) shall include the statement and the demonstration required by paragraphs (2) and (4) of section 3025(d) of this title; and

"(B) may not be approved unless the Assistant Secretary approves such statement and such demonstration.

"(34) The plan shall provide an assurance that the State agency will coordinate programs under this subchapter and subchapter X of this chapter, if applicable.

"(35) The plan shall--

"(A) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits under this subchapter, if applicable; and

"(B) specify the ways in which the State agency intends to implement the activities."


Subsec. (a)(37) to (40). Pub.L. 106-501, § 306(20), struck out former pars. (37) to (40). Prior to amendment, former pars. (37) to (40) read as follows:

"(37) The plan shall identify for each fiscal year, the actual and projected additional costs of providing services under this subchapter, including the cost of providing access to such services, to older individuals residing in rural areas in the State (in accordance with a standard definition of rural areas specified by the Assistant Secretary).

"(38) The plan shall provide assurances that funds received under this subchapter will not be used to pay any part of a cost (including an administrative cost) incurred by the State or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this subchapter.

"(39) The plan shall provide assurances that preference in receiving services under this subchapter will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this subchapter.

"(40) The plan shall provide assurances that if the State receives funds appropriated under section 3023(g) of this title the State agency and area agencies on aging will expend such funds to carry out part G of this subchapter."
Subsec. (a)(41), (42). Pub.L. 106-501, § 306(21), redesignated former pars. (41) and (42) as pars. (23) and (24).

Subsec. (a)(43). Pub.L. 106-501, § 306(20), struck out former par. (43). Prior to amendment, former par. (43) read as follows:

"The plan shall provide that the State agency shall issue guidelines applicable to grievance procedures required by section 3026(a)(6)(P) of this title."


Subsec. (f). Pub.L. 106-501, § 801(c)(4)(B), struck out the designator for par. (1) and struck out par. (2). Prior to amendment, par. (2) read as follows:

"Information disclosed under section 3026(a)(14)(B)(i) of this title or subsection (a)(7)(C)(ii)(I) of this section may be disclosed to the public by the State agency or the State only if such information could be disclosed under section 552 of Title 5 by an agency of the United States."


Subsec. (b)(2). Pub.L. 103-171, § 2(9)(B), substituted "such requirement" for "the requirement described in paragraph (3)(B) of subsection (a) of this section".

Subsecs. (d), (e). Pub.L. 103-171, § 3(a)(5)(A), substituted "Assistant Secretary's" for "Commissioner's" wherever appearing.

1992 Amendments. Subsec. (a). Pub.L. 102-375, § 307(a)(1), inserted "the succeeding sentence and" following "provided in".

Pub.L. 102-375, § 307(a)(2), added provisions requiring State, if Commissioner determines that State has failed in 2 successive years to comply with requirements of this subchapter, to submit plan for 1-year period that meets such criteria until Commissioner determines that State is in compliance with such requirements.

Subsec. (a)(1). Pub.L. 102-375, § 102(b)(10)(F), substituted "agencies on aging in" for "agencies in".


Subsec. (a)(7). Pub.L. 102-375, § 307(c), redesignated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (a)(8). Pub.L. 102-375, § 307(d), added provisions requiring State, in conducting evaluations and hearings, to solicit views and experiences of entities knowledgeable about needs and concerns of low-income minority individuals.

Pub.L. 102-375, § 904(a)(13)(A)(i), substituted "greatest economic need and older individuals with greatest social need" for "the greatest economic or social needs".

Subsec. (a)(9). Pub.L. 102-375, § 102(b)(4), substituted "information and assistance" for "information and referral".

Subsec. (a)(10). Pub.L. 102-375, § 307(d), substituted "section 3030i(1) of this title" for "section 3030i(1) of this title".

Subsec. (a)(11). Pub.L. 102-375, § 307(e), substituted "governments--" for "governments, preference shall be given to individuals aged 60 or older", and added subpars. (A) and (B).

Subsec. (a)(12). Pub.L. 102-375, § 307(f), substituted "The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 3058g of this title and this subchapter." for "The plan shall provide the following assurances, with respect to a long-term care ombudsman program:", and struck out subpars. (A) through (K),
which required State agency: to establish and operate an Office of the State Long-Term Care Ombudsman and carry out program to investigate and resolve complaints and promote participation in program, to provide access to facilities and records, to establish reporting system, to prevent disclosure of files, to consider views of area agencies, older individuals and providers, to prevent conflicts of interest, to provide legal counsel to Office, to require Office to prepare annual report, recommend changes in laws, regulations and policies, provide information to public, legislators and others, train staff of Office, coordinate services with other programs, and include local ombudsman entities as subdivisions of Office, to ensure Office representatives would not be liable under State law for good faith performance of their duties, to ensure that interference with Office representatives in performance of their duties would be unlawful, to prohibit retaliation for filing complaint with or providing information to Office, and to prohibit investigations by untrained Office representatives.

Subsec. (a)(13)(A). Pub.L. 102-375, § 904(a)(13)(A)(ii)(I), (II), substituted "to older individuals" for "to individuals aged 60 or older" and "by older individuals" for "by the elderly".

Subsec. (a)(13)(B). Pub.L. 102-375, § 102(b)(10)(C), substituted "area agency on aging" for "area agency".

Pub.L. 102-375, § 307(g)(1), inserted "(other than under section 3023(b)(3) of this title)" following "under this subchapter".

Pub.L. 102-375, § 904(a)(13)(A)(ii)(II), substituted "subparagraph" for "subclause".

Subsec. (a)(13)(F). Pub.L. 102-375, § 307(g)(2), inserted "dietitians (or individuals with comparable experience)," following "advice of" and substituted "project will" for "project may".


Pub.L. 102-375, § 307(g)(3), struck out "and" following "sources;".

Subsec. (a)(13)(I). Pub.L. 102-375, § 102(b)(10)(C), substituted "area agency on aging" for "area agency".

Pub.L. 102-375, § 307(g)(4), substituted "chapter;" for "chapter.".
amount expended from funds received under this chapter by such State in fiscal year 1987 to carry out paragraph (12) as in effect before the effective date of the Older Americans Act Amendments of 1987. This paragraph shall not apply to American Samoa, Guam, the Virgin Islands, the Trust Territory of the Pacific Islands, and the Commonwealth of the Northern Mariana Islands."


Subsec. (a)(24). Pub.L. 102-375, § 307(l), in subpar. (A), substituted "identify individuals eligible for assistance under this chapter, with special emphasis on--" for "identify older individuals who are eligible for assistance under this subchapter, with special emphasis on older individuals with greatest economic need (with particular attention to low-income minority individuals), and older individuals who reside in rural areas; and", and added cls. (i) through (vi), and in subpar. (B), substituted "inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance," for "inform such individuals of the availability of such assistance.".

Subsec. (a)(30). Pub.L. 102-375, § 307(m), substituted "The plan shall include the assurances and description required by section 3058d(a) of this title" for "The plan shall provide assurances that if the State receives funds appropriated under section 3023(g) of this title, the State agency and area agencies on aging will expend such funds to carry out part G of this subchapter".

Subsec. (a)(31). Pub.L. 102-375, § 307(n), struck out "The plan shall provide that the State agency--", formerly preceding subpar. (A), in subpar. (A), substituted "If 50 percent or more of the area plans in the State provide for an area volunteer services coordinator, as described in section 3026(a)(12) of this title, the State plan shall provide for a State volunteer services coordinator, who shall--" for "from funds allotted for fiscal year 1989 under section 3024(a) of this title for part B of this subchapter that are attributable to the amount appropriated under section 3023(a)(3) of this title, will make funds available to eligible area agencies on aging to carry out section 3026(a)(6)(P) of this title and, in distributing such funds among eligible area agencies, will give priority to area agencies on aging based on--", in cl. (i), substituted "encourage area agencies on aging to provide for area volunteer services coordinators;" for "the number of older individuals with greatest economic need (as defined in section 3022(20) of this title) residing in their respective planning and service areas; and", in cl. (ii), substituted "coordinate the volunteer services offered between the various agencies on aging", for "the inadequacy in such areas of outreach activities and application assistance of the type specified in section 3026(a)(6)(P) of this title", and added cls. (iii) through (v), in subpar. (B), substituted "If fewer than 50 percent of the area plans in the State provide for an area volunteer services coordinator, the State plan may provide for the State volunteer services coordinator described in subparagraph (A)." for "will require, as a condition of eligibility to receive funds under this paragraph, an area agency on aging to submit an application that--", and struck out cls. (i) through (iii), which related to description of activities for which funds were sought, evaluation of activities by area agency, and, inclusion of assurances that area agency would prepare and submit to State agency report of activities conducted with funds provided under this paragraph, an area agency on aging to submit an application of the type specified in section 3026(a)(6)(P) of this title, and added cls. (iii) through (v), in subpar. (B), which required distribution of eligibility information received under section 3012(a)(20) of this title, and for medicaid, to area agencies, and struck out subpar. (D), which required submission to Commissioner of report on evaluations required to be submitted under subpar. (B) of this par.


Subsec. (b)(1). Pub.L. 102-375, § 307(o), inserted provisions prohibiting approval of plan unless Commissioner determines that formula submitted under section 3025(a)(2)(D) of this title complies with guidelines under section 3025(a)(2)(C) of this title.

Subsec. (b)(2). Pub.L. 102-375, § 904(a)(13)(B), substituted "paragraph" for "clause".

Subsec. (c). Pub.L. 102-375, § 307(q), redesignated existing provisions as par. (1) and added pars. (2) and (3).

Pub. L. 102-375, § 307(r), redesignated subsec. (g) as subsec. (f)(1) and added subsec. (f)(2).


1988 Amendments. Subsec. (a)(3)(A). Pub. L. 100-628, § 705(6), substituted a period for "; and" after "meet such need".

1987 Amendments. Subsec. (a). Pub. L. 100-175, § 182(k)(1), in provision preceding par. (1) substituted "Each such plan shall comply with all of the following requirements:" for "Each such plan shall--".

Subsec. (a)(1). Pub. L. 100-175, § 182(k)(2), inserted "The plan shall" after "(1)" and substituted a period for the semicolon at the end thereof.

Subsec. (a)(2). Pub. L. 100-175, § 182(k)(3), inserted "The plan shall" after "(2)" and substituted a period for the semicolon at the end thereof.


Subsec. (a)(3)(B). Pub. L. 100-175, § 182(k)(4)(B), inserted "The plan shall" after "(B)" and substituted a period for the semicolon at the end thereof.

Subsec. (a)(4). Pub. L. 100-175, § 182(k)(5), inserted "The plan shall" after "(4)" and substituted a period for the semicolon at the end thereof.

Subsec. (a)(5). Pub. L. 100-175, § 182(k)(6), inserted "The plan shall" after "(5)" and substituted a period for the semicolon at the end thereof.

Subsec. (a)(6). Pub. L. 100-175, § 182(k)(7), inserted "The plan shall" after "(6)" and substituted a period for the semicolon at the end thereof.

Subsec. (a)(7). Pub. L. 100-175, § 182(k)(8), inserted "The plan shall" after "(7)" and substituted a period for the semicolon at the end thereof.

Subsec. (a)(8). Pub. L. 100-175, § 128, inserted ", and public hearings on," after "evaluations of".

Pub. L. 100-175, § 132(c)(1), inserted ", including an evaluation of the effectiveness of the State agency in reaching older individuals with the greatest economic or social needs, with particular attention to low-income minority individuals" before semicolon.

Pub. L. 100-175, § 182(k)(9), inserted "The plan shall" after "(8)" and substituted a period for the semicolon at the end thereof.

Subsec. (a)(9). Pub. L. 100-175, § 182(k)(10), inserted "The plan shall" after "(9)" and substituted a period for the semicolon at the end thereof.

Subsec. (a)(10). Pub. L. 100-175, § 140(c)(1), which directed that par. (10) be amended by substituting "nutrition services, or in-home services (as defined in section 3030i(1) of this title)" for "including nutrition services," was executed by making the substitution for "or nutrition services," to reflect the probable intent of Congress and a previous amendment made by Pub. L. 98-459, § 307(a)(2). See 1984 Amendment note under this section.

Pub. L. 100-175, § 182(k)(11), inserted "The plan shall" after "(10)" and substituted a period for the semicolon at the end thereof.

Subsec. (a)(11). Pub. L. 100-175, § 182(k)(12), inserted "The plan shall" after "(11)" and substituted a period for the semicolon at the end thereof.

Subsec. (a)(12)(A). Pub. L. 100-175, § 129(d), substituted provisions requiring the establishment of an Office of the State Long-Term Care Ombudsman (subsequently referred to as the "Office") for provisions which had formerly required only the establishment of a "long-term care ombudsman program", added provisions requiring the investigation and resolution of complaints made by or on behalf of older individuals relating to actions, inaction, or decisions of providers, or their representatives, of long-term care services, of public agencies, or of social service agencies, and struck out provisions relating to the monitoring of the development and implementation of laws, regulations, and policies with respect to long-term care facilities and the providing of information to public agencies regarding the problems of persons residing in long-term care facilities.

Subsec. (a)(12)(B) to (E). Pub. L. 100-175, § 129(d), re-enacted subpars. (B) to (E) without change except for grammatical changes required to turn subpars. (B) to (E) into separate sentences.

Subsec. (a)(12)(F) to (K). Pub. L. 100-175, § 129(d), added subpars. (F) to (K).

Subsec. (a)(13). Pub. L. 100-175, § 182(k)(13), in
provision preceding subpar. (A) inserted "The plan shall" after ")13)" and in subpar. (I) substituted a period for the semicolon at the end thereof.

Subsec. (a)(13)(I). Pub.L. 100-175, § 136(c)(1), inserted ", and to individuals with disabilities who reside at home with and accompany older individuals who are eligible under this chapter" before semicolon.

Subsec. (a)(14). Pub.L. 100-175, § 182(k)(14), in provision preceding subpar. (A) inserted "The plan shall" after ")14)" and in subpar. (E) substituted a period for the semicolon at the end thereof.

Subsec. (a)(15). Pub.L. 100-175, § 182(k)(15), in provision preceding subpar. (A) inserted "The plan shall" after ")15)" and in subpar. (D) substituted a period for the semicolon at the end thereof.

Subsec. (a)(16). Pub.L. 100-175, § 144(d)(1), substituted ", if funds are not appropriated under section 3023(g) of this title for a fiscal year, provide that for such fiscal year for services for the prevention" for "provide for services for the prevention" in the provisions preceding subpar. (A).

Pub.L. 100-175, § 182(k)(16), in provision preceding subpar. (A) inserted "The plan shall" after ")16)" and in subpar. (C) substituted a period for the semicolon at the end thereof.

Subsec. (a)(17). Pub.L. 100-175, § 182(k)(17), inserted "The plan shall" after ")17)" and substituted a period for the semicolon at the end thereof.

Subsec. (a)(18). Pub.L. 100-175, § 182(k)(18), inserted "The plan shall" after ")18)" and substituted a period for the semicolon at the end thereof.

Subsec. (a)(19). Pub.L. 100-175, § 182(k)(19), inserted "The plan shall" after ")19)" and substituted a period for the semicolon at the end thereof.

Subsec. (a)(20). Pub.L. 100-175, § 182(k)(20)(A), in provision preceding subpar. (A) inserted "The plan shall" after ")20)".

Subsec. (a)(20)(A). Pub.L. 100-175, § 155(e)(2)(A), substituted "sections 3026(a)(2)(A) and 3026(a)(6)(P) of this title" for "section 3026(a)(2)(A) of this title".


Subsec. (a)(21). Pub.L. 100-175, § 129(e), substituted provisions requiring the State plan to provide that the State agency, from funds allotted under section 3024(a) of this title for part B and for paragraph (12) (relating to the State long-term care ombudsman) expend to carry out paragraph (12), for each fiscal year in which the allotment for part B for the State is not less than the allotment for fiscal year 1987 for part B for such State, an amount which is not less than the amount expended from funds received under this chapter by such State in fiscal year 1987 to carry out paragraph (12) as in effect before the effective date of the Older Americans Act Amendments of 1987, for former provisions which had required the State plan to provide that the State agency, from funds allotted under section 3024(a) of this title for part B would use an amount equal to an amount not less than 1 percent of such allotment or $20,000, whichever is greater, for the purpose of carrying out the provisions of clause (12), except that (A) the requirement of this clause did not apply in any fiscal year in which a State spent from State or local sources an amount equal to the amount required to be spent by this clause.

Subsec. (a)(22). Pub.L. 100-175, § 130(b), added par. (22).

Subsec. (a)(23). Pub.L. 100-175, § 131(b), added par. (23).


Subsec. (a)(27). Pub.L. 100-175, § 140(c)(2), added par. (27).

Subsec. (a)(28). Pub.L. 100-175, § 141(c), added par. (28).


Subsec. (g).  

Pub. L. 100-175, § 137(b), added subsec. (g).

1984 Amendments.  


Subsec. (a)(10).  Pub. L. 98-459, § 307(a)(2)(A), substituted "supportive services or nutrition services" for "supportive services, including nutrition services".

Pub. L. 98-459, § 307(a)(2)(B), inserted ", or where such services are directly related to such State or area agency on aging's administrative functions, or where such services of comparable quality can be provided more economically by such State or area agency on aging" before the semicolon.

Subsec. (a)(12)(A).  Pub. L. 98-459, § 307(a)(3)(A), substituted ", other than an agency or organization which is responsible" for "which is not responsible" in provisions preceding cl. (i).

Pub. L. 98-459, § 307(a)(3)(B), substituted "which is an association" for "which is not an association" in provisions preceding cl. (i).

Pub. L. 98-459, § 307(a)(3)(C), substituted "which provides an individual who will, on a full-time basis--" for "which will--" in provisions preceding cl. (i).


Subsec. (a)(15)(B).  Pub. L. 98-459, § 307(a)(6), substituted provisions requiring assurances regarding the furnishing of legal assistance by grantees administering programs designed to provide legal assistance to older individuals with social or economic need for provisions requiring assurances regarding the furnishing of legal services by grantees who were either recipients of funds under the Legal Services Corporation Act or who administered programs designed to provide legal services to all older individuals with social or economic need.


Subsec. (a)(20)(B)(ii).  Pub. L. 98-459, § 307(a)(7), struck out the period at the end and inserted in lieu thereof a semicolon and "and".


Subsec. (b)(1).  Pub. L. 98-459, § 307(b), substituted "the Commissioner finds" for "he finds".

Subsec. (d).  Pub. L. 98-459, § 307(c)(1), substituted "in the Commissioner's discretion" for "in his discretion".

Pub. L. 98-459, § 307(c)(2), substituted "until the Commissioner is satisfied" for "until he is satisfied", "Until the Commissioner is so satisfied" for "Until he is so satisfied", and "the Commissioner shall prescribe" for "he shall prescribe", respectively.

Pub. L. 98-459, § 307(c)(3), substituted "the provisions of this section" for "the provisions of..."
section 307”.

Subsec. (e)(1). Pub.L. 98-459, § 307(d)(1)(A), substituted "designated by the Commissioner" for "designated by him".

Pub.L. 98-459, § 307(d)(1)(B), substituted "the Commissioner's action is based" for "he based his action".


Subsec. (a)(3)(A). Pub.L. 97-115, § 3(d), substituted "supportive services" for "social services".

Subsec. (a)(10). Pub.L. 97-115, § 3(d), substituted "supportive services" for "social services".

Subsec. (a)(13)(A). Pub.L. 97-115, § 7(b), substituted "aged 60 or older and to their spouses, and may be made available to handicapped or disabled individuals who have not attained 60 years of age but who reside in housing facilities occupied primarily by the elderly at which congregate nutrition services are provided" for "aged 60 or older, and to their spouses".

Subsec. (a)(13)(B). Pub.L. 97-115, § 7(c), substituted "primary consideration shall be given to the provision of meals in a congregate setting, except that each area agency (i) may award funds made available under this subchapter to organizations for the provision of home delivered meals to older individuals in accordance with the provisions of subpart 2 of part C, based upon a determination of need made by the recipient of a grant or contract entered into under this subchapter".

Subsec. (a)(13)(C)(ii). Pub.L. 97-115, § 7(d), added ", to facilitate access to such meals, and to provide other supportive services directly related to nutrition services" following "number of meals served by the project involved".

Subsec. (a)(13)(D). Pub.L. 97-115, § 3(d), substituted "in the case of meals served in a congregate setting," at the beginning of subpar. (D) preceding "a site for such services", substituted "supportive services" for "social services", and struck out "or home delivered meals are furnished to eligible individuals who are homebound" at the end of subpar. (D) following "transportation to such site is furnished".

Subsec. (a)(13)(I). Pub.L. 97-115, § 7(f), substituted "(I) each area agency shall establish procedures that will allow nutrition project administrators the option to offer a meal, on the same basis as meals are provided to elderly participants, to individuals providing volunteer services during the meal hours" for "(I) each State agency may only for fiscal years 1979 and 1980, use not to exceed 20 percent for the amounts allotted under part C to the State for supportive services, including recreational activities, informational services, health and welfare counseling, and referral services, directly related to the delivery of congregate or home delivered meals, except that the Commissioner may approve an application from a State to use not to exceed 50 percent of its amount allotted under part C in areas with unusually high supportive services costs".

Subsec. (a)(16) to (18). Pub.L. 97-115, § 7(g), added pars. (16) and (17) and redesignated former par. (16) as (18).

Subsec. (b)(2). Pub.L. 97-115, § 7(h), redesignated former par. (3) as (2). Former par. (2), which related to the authority of the Commissioner to waive particular requirements of State plans for fiscal years 1979 and 1980, was struck out.

Subsec. (b)(3). Pub.L. 97-115, § 7(h), redesignated par. (3) as (2).

Effective and Applicability Provisions

1992 Acts. Amendment by sections 307 and 708(c)(4) of Pub.L. 102-375 not to apply with respect to fiscal year 1993, see section 4(b) of Pub.L. 103-

Amendment by sections 307 and 708(c)(4) of Pub.L. 102-375 not to apply with respect to fiscal year 1992, see section 905(b)(2), (6) of Pub.L. 102-375, set out as a note under section 3001 of this title.

1987 Acts. Amendment by Pub.L. 100-175 effective Oct. 1, 1987, except that such amendment shall not apply with respect to any area plan submitted under section 3026(a) of this title or any State plan submitted under section 3027(a) of this title and approved for any fiscal year beginning before Nov. 29, 1987, see section 701(a), (b) of Pub.L. 100-175, set out as a note under section 3001 of this title.


Prior Provisions


Provisions similar to those comprising this section were contained in Pub.L. 89-73, Title III, § 305, as added Pub.L. 93-29, Title III, § 301, May 3, 1973, 87 Stat. 44, which related to the payment of grants or contracts, was omitted in the general revision and reorganization of this subchapter by Pub.L. 95-478, Title I, § 103(b). Oct. 18, 1978, 92 Stat. 1524. See section 3029 of this title.

Assessment of Unsatisfied Demand for Supportive Services Provided at Senior Centers and Other Sites

Section 111 of Pub.L. 100-175 provided that:

"(a) Report.--Not later than September 30, 1989, the Commissioner on Aging shall submit to the Congress a report--

"(1) assessing the national unmet need for supportive services, nutrition services, and multipurpose senior centers by summarizing in detail for each State the results of the most recent evaluation conducted by the State agency under the then current plan (including any revision thereof) submitted under section 307(a)(3)(A) of the Older Americans Act of 1965 (42 U.S.C. 3027(a)(3)(A)) [subsec. (a)(3)(A) of this section], and

"(2) containing the recommendations of the Secretary with respect to the need for administrative action and legislation relating to satisfying the demand for supportive services provided at senior centers established under such title [probably means Title III of Pub.L. 89-73 which is classified to this subchapter] and at other sites.

"(b) Issuance of regulations.--For purposes of obtaining adequate information to be included in the report required by subsection (a), the Commissioner on Aging shall issue, under the authority of section 307(a) of the Older Americans Act of 1965 (42 U.S.C. 3027(a)) [subsec. (a) of this section], such regulations as may be necessary to ensure that the evaluations required to be summarized in such report include data that are objectively collected and statistically valid."

Study of Ombudsman Program

Section 129(b) of Pub.L. 100-175 provided that:

"(1) The Commissioner on Aging shall conduct a study concerning involvement in the ombudsman program established under section 307(a)(12) of the Older Americans Act of 1965 (42 U.S.C. 3027(a)) [subsec. (a)(12) of this section] and its impact upon issues and problems affecting--

"(A) residents of board and care facilities and other similar adult care homes who are older individuals (as defined in section 302(10) of such Act) [section 3022(10) of this title], including recommendations for expanding and improving ombudsman services in such facilities, and

"(B) the effectiveness of recruiting, supervising, and retaining volunteer ombudsmen.

"(2) The Commissioner shall prepare and submit a report to the Congress on the findings and recommendations of the study described in paragraph (1) not later than December 31, 1989."
Additional State plan requirements, see 42 USCA § 3058d.

Administration on Aging--
Generally, see 42 USCA §§ 3011 and 3012.
Evaluation of programs, see 42 USCA § 3017.

Grants to States under plans approved under this section for purposes of--
Disease prevention and health promotion services, see 42 USCA § 3030m.
Home delivery of nutrition services for older individuals, see 42 USCA § 3030f.
Nutrition services, see 42 USCA § 3030e.
Supportive services generally, see 42 USCA § 3030d.

Grants to tribal organizations, applications to provide assurance that provisions of this section to be complied with for acquisition, alteration or renovation of facilities to serve as multipurpose senior centers, see 42 USCA § 3057e.

Long-term care facility defined for purposes of programs for older Americans, see 42 USCA § 3002.

Technical assistance and materials to agencies carrying out nutrition education programs in accord with this section, see 42 USCA § 3020e.

Waiver of licensed nursing services requirement, notice to State long-term care ombudsman for purposes of--
Nursing facility, see 42 USCA § 1396r.
Skilled nursing facility, see 42 USCA § 1395i-3.

LIBRARY REFERENCES

American Digest System
Social Security and Public Welfare k175.5.
United States 82(1).
Key Number System Topic Nos. 356A, 393.

Corpus Juris Secundum

CJS Witnesses § 318, Application of Privilege to Public Entities or Officers.

RESEARCH REFERENCES

Treatises and Practice Aids

42 U.S.C.A. § 3027, 42 USCA § 3027


END OF DOCUMENT
MT CONST Art. 2, § 10

MONTANA CODE ANNOTATED
THE CONSTITUTION OF THE STATE OF MONTANA
ARTICLE II. DECLARATION OF RIGHTS
Section 10, Right of privacy

The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest.

NOTES, REFERENCES, AND ANNOTATIONS

Convention Notes

New provision prohibiting any invasion of privacy unless the good of the state makes it necessary.

Constitution Cross-References

Right to know, Art. II, sec. 9, Mont. Const.

Searches and seizures, Art. II, sec. 11, Mont. Const.

Personal papers of Executive Branch officers, 2-6-304.

Confidentiality of court proceedings in actions for dissolution, criminal conversation, or seduction, 3-1-313.

Confidentiality of proceedings of Judicial Nominating Commission, 3-1-1007.

Confidentiality of Judicial Standards Commission, 3-1-1105.


Montana Library Records Confidentiality Act, Title 22, ch. 1, part 11.

Privileged communications, Title 26, ch. 1, part 8; Art. V, M.R.Ev. (see Title 26, ch. 10).

Media Confidentiality Act, Title 26, ch. 1, part 9.

Confidentiality of unfair trade practices investigation, 30-14-114.

Consumer reporting agencies, Title 31, ch. 3, part 1.

Confidentiality of reports and examinations of financial institutions to Department of Administration, 32-1-234, 32-2-307.

Confidentiality of hearing on unsafe operation or removal of officer of bank or trust, 32-1-910.

Confidentiality in electronic funds transfer systems, 32-6-105, 32-6-106.

Social workers -- confidentiality of communications, 37-22-401.

Confidentiality of premarital test certificate, 40-1-208.

Confidentiality of conciliation court proceedings, 40-3-116.

Confidentiality of parenting proceedings, 40-4-216.

Confidentiality of artificial insemination information, 40-6-106.

Privilege of physician-patient communications suspended in certain circumstances, 40-6-106, 41-3-201, 41-3-204, 41-3-437.

Confidentiality in paternity proceedings, 40-6-111, 40-6-114, 40-6-120.

Confidentiality of birth certificate under certain circumstances, 40-6-123.

Confidentiality and disclosure of child abuse and neglect proceedings, 41-3-205.

Privilege of husband-wife communications suspended in certain actions, 41-3-437, 45-5-604.

Confidentiality of youth placement committee meetings and records, 41-5-125.

Access to Youth Court records, 41-5-215.

Attendance at Youth Court adjudicatory hearing, 41-5-1502.

Criminal justice information, Title 44, ch. 5.
MT CONST Art. 2, § 10

Criminal intelligence information section, Title 44, ch. 5, part 5.

Criminal intelligence information -- protection of individual privacy, 44-5-515.

Criminal offense of violating privacy in communications, 45-8-213.

Confidentiality of records of the state, employers, labor organizations, and employment agencies with regard to age, sex, and race, 49-2-102.

Confidentiality of inhosptal medical staff committee information, Title 50, ch. 16, part 2.

Uniform Health Care Information Act, Title 50, ch. 16, part 5.

Confidentiality of vehicle accident reports, 61-7-114.

Confidentiality of data relating to agricultural chemical ground water protection, 80-15-108.

Information obtainable by Governor during energy emergency, 90-4-304.

Constitutional Convention Transcript Cross-References

Adoption, Trans. 2933, 2934.


Debate -- committee report, Trans. 1643, 1680 through 1685, 1688, 1730, 1733, 1850 through 1853, 2488.

Debate -- style and drafting report, Trans. 2501, 2921.


Final consideration, Trans. 2637, 2638.


Constitution Case Notes

Private Searches
Police Searches
Electronic Surveillance

Public and Private Records

Miscellaneous

PRIVATE SEARCHES

Unproved Statements of Child Informant as Sole Basis for Issuance of Warrant: A child observed marijuana plants growing on Worrall's property and reported it to police. The child's observation was never corroborated by the police. Worrall averred that allowing a search of his property based on the uncorroborated claim of an unproved 11-year-old child, after only a 15-minute interview, was unreasonable and that the District Court erred in finding probable cause for the search warrant because unverified statements of an unproved informant, much less a child informant, could not serve as the sole basis for the issuance of the warrant. Citing St. v. Adams, 284 M 25, 943 P2d 955, 54 St. Rep. 717 (1997), the Supreme Court noted that corroboration of an informant's testimony through other sources is necessary only when the information is hearsay or the informant is anonymous. In this case, the child was not anonymous and the information was based on personal observation rather than hearsay, so corroboration was unnecessary. The court observed that information provided to police that is motivated by good citizenship is a reliable basis for determining probable cause and that nothing in the record indicated that the child's report should be viewed more critically than a similar report from an adult. Thus, the unproved statement of the child informant may serve as the sole basis for issuance of a search warrant. St. v. Worrall, 1999 MT 55, 293 M 439, 976 P2d 968, 56 St. Rep. 225 (1999).

Privacy Section of Montana Constitution -- Contemplates Invasion Only by State Action: Sheriff's officers, armed with a search warrant, gained entrance to the defendants' rented house after their landlord, who was trespassing at the time, discovered a large number of marijuana plants growing there and reported his discovery to the Sheriff. The narrow issue on appeal was whether the fruits of a search conducted by a private citizen, without any type of governmental involvement, are properly the subject of exclusion. The Supreme Court overruled the well-established holding that private searches invade privacy rights protected by the privacy section of the Montana Constitution. The Supreme Court held that the privacy section of the constitution contemplates privacy invasion only by state action. Unless specifically provided otherwise,
citizens' rights articulated in the constitution proscribe only state action. Therefore, if a private citizen, such as the landlord in this case, invades the privacy of another citizen, there is no violation of the constitution. The exclusionary rule is a rule of court procedure to deny admission of the fruits of illegally seized evidence to deter unlawful police activities and to preserve the integrity of the judiciary. In this case, judicial integrity does not require exclusion of the evidence. St. v. Long, 216 M 65, 700 P2d 153, 42 St. Rep. 643 (1984).

"Stop and Frisk" by Private Security Guard -- No Violation of Right to Privacy: A "stop and frisk" action by a private security guard taken to protect a hotel and its occupants against trespassers in the process of committing an offense was not a violation of the right to privacy set forth in this section of the Montana Constitution when the security guard had a "reasonable suspicion" that a crime was taking place. St. v. Bradford, 210 M 130, 683 P2d 924, 41 St. Rep. 962 (1984).

Failure to Show Evidence Tainted by Citizen Search: In a motion to suppress evidence, defendant claimed that use of the evidence would violate his constitutional right to privacy because an informant supplying information to a law officer seeking a search warrant had been sent into defendant's home by that law officer. The Supreme Court refused to order the suppression of the evidence because the informant did not take any evidence from defendant's residence and because the defendant had not met the initial burden of establishing an unconstitutional intrusion or a factual nexus between the intrusion and the challenged evidence. St. v. O'Neill, 208 M 386, 679 P2d 760, 41 St. Rep. 420 (1984).

Citizen Searches -- Exclusionary Rule Partly Grounded in Judicial Integrity: The Montana Constitution provides that "the right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest". The judicial system must not become an accomplice to constitutional violations by admitting illegally obtained evidence. Therefore, evidence obtained by a private citizen in violation of the state constitutional right to privacy is subject to the exclusionary rule and may not be admitted into evidence in a criminal trial in Montana. St. v. Van Haele, 198 M 522, 649 P2d 1311, 39 St. Rep. 1586 (1982), overruled in St. v. Long, 216 M 65, 700 P2d 153, 42 St. Rep. 643 (1985).

Citizen Searches -- Search of Unit by Storage

Rental Business Manager: After renter of storage unit entered his unit, manager of the storage unit rental business wanted to know how much longer he would be on the premises and wondered what renter was doing, as the unit's door was closed and there were no windows or lights in the unit. She opened the door after a knock and calling out to renter produced no result. Renter was sitting on the floor pointing a gun at the manager and had two suitcases behind him in the dim interior of the unit. Manager left. Pursuant to a suggestion of the business' home office, the manager removed the hinge pins on the door, cut off the padlock, entered, opened a suitcase, found a number of bottles of pills, and called the police. Based on the manager's information the police obtained a search warrant, found over 100 bottles of pills in the suitcases and a purse, and renter was arrested, charged, and convicted of criminal possession of dangerous drugs with intent to sell them. On appeal it was found that the evidence was obtained in violation of renter's state constitutional right to privacy and should have been excluded. The conviction was reversed because it was not supported by the remaining evidence or the law. St. v. Van Haele, 198 M 522, 649 P2d 1311, 39 St. Rep. 1586 (1982), overruled in St. v. Long, 216 M 65, 700 P2d 153, 42 St. Rep. 643 (1985).

Entry to Defendant's Porch -- No Private Search Conducted: There was testimony that two men entered the defendant's porch while the defendant was not at home. The same two men returned and talked to the defendant. The two men returned for a third time with a Deputy Sheriff. After obtaining a search warrant, the Deputy Sheriff searched the defendant's premises. After certain stolen items were found, the defendant was arrested and later convicted of theft. The court rejected the defendant's argument that the two men conducted an unlawful search the first time they entered his porch in violation of the defendant's right of privacy. St. v. Brown, 199 M 472, 649 P2d 1306, 39 St. Rep. 1531 (1982).

Landlord's Inadvertent Observation as Basis for Search Warrant -- Controlled Substances: The defendant, who had signed a lease allowing his landlord the right to enter the defendant's apartment, borrowed a vacuum cleaner from the landlord, who, upon entering the defendant's room to retrieve the vacuum, saw light coming from a closet and inadvertently discovered marijuana and drug paraphernalia. The District Court did not err in denying the defendant's motion to suppress the evidence taken after a search warrant was obtained. The landlord was justified in entering the room to
show it to prospective lessees or to retrieve the vacuum. Once the landlord was in the apartment, he was justified in inspecting the closet to see if the cause of the light constituted a fire hazard. The landlord could, under the circumstances, permit the police officer to observe the items in the closet, and the officer's observation could be used as a basis for the warrant.  


\textbf{Citizen Search -- Defendants' Right of Privacy Violated:} A warrantless citizen search violated defendants' right of privacy without the showing of a compelling state interest. Since the citizens were acting in their individual capacities and not for the State, State action was not involved, and the searchers could never be in a position of showing a compelling State interest, which is the only exception to the restriction against the invasion of individual privacy. Although defendants were aware that their rented house was for sale and being shown to prospective buyers in their absence, defendants did not consent to the search under their bed and thereby waive their right of privacy. \textit{St. v. Hyem}, 193 M 51, 630 P2d 202, 38 St. Rep. 891 (1981), overruled in \textit{St. v. Long}, 216 M 65, 700 P2d 153, 42 St. Rep. 643 (1985).

\textbf{Detaining Suspected Shoplifter Without Arrest -- Unconstitutional:} The plaintiff was accused of shoplifting by the defendant's employee. Plaintiff's purse was searched, and nothing was found. Plaintiff was then detained under the authority of 46-6-503 (now repealed) until the police arrived and arrested her. After being acquitted of the shoplifting charge, the plaintiff brought suit for false arrest. The trial court instructed the jury in the words of 46-6-503 over plaintiff's objection. On appeal, the Supreme Court said there must be a showing of compelling state interest that would justify the infringement of plaintiff's right to privacy. The mere fact that defendant's conduct comporting with the merchants' detention statute does not establish a compelling state interest. No compelling state interest was shown which would justify the very serious invasion of a person's privacy that occurred. Insofar as 46-6-503 (now repealed) permits a merchant with immunity to stop and detain an individual for up to 30 minutes without making an arrest, it is unconstitutional as an invasion of the right to privacy and the right to be secure from unreasonable searches and seizures guaranteed by Art. II, sec. 10 and 11, Mont. Const., as it applies to this case. \textit{Duran v. Buttrey Food, Inc.}, 189 M 381, 616 P2d 327, 37 St. Rep 1545 (1980).

\textbf{Application to Private Individuals of Montana Search and Seizure Law:} Although under the federal constitution illegally obtained evidence is admissible when seized by a nongovernmental agent not acting in concert with any governmental agency, the Montana Constitution, through Art. II, sec. 10 and 11, affords an individual greater explicit protection than do cases interpreting the federal constitution. The search and seizure provisions of Montana law apply to private individuals as well as law enforcement officers. Therefore, evidence obtained through an illegal invasion of privacy by an individual is not to be admitted. A search and seizure performed by a private individual by means of an illegal trespass is a significant invasion of individual privacy. \textit{St. v. Helfrich}, 183 M 484, 600 P2d 816 (1979), overruled in \textit{St. v. Long}, 216 M 65, 700 P2d 153, 42 St. Rep. 643 (1985).

\textbf{Suppression of Evidence:} Exclusionary rule of evidence must apply to all searches and seizures, especially when there is also violation of defendant's protection against self-incrimination, and thus motion to suppress was properly granted where employer removed marijuana from defendant's coat in an unconstitutional invasion of defendant's privacy. \textit{St. v. Coburn}, 165 M 488, 530 P2d 442 (1974), overruled in \textit{St. v. Long}, 216 M 65, 700 P2d 153, 42 St. Rep. 643 (1985).

\textbf{POLICE SEARCHES}

\textbf{Warrantless Search of Vehicle Exterior by Drug-Sniffing Dog -- Expectation of Privacy in Vehicle Parked in Public Area -- Particularized Suspicion Required:} Following an anonymous tip that Tackitt was involved in drug trafficking and that he had a quantity of marijuana in the trunk of his car, a drug task force officer conducted an exterior canine search of Tackitt's car when it was parked outside Tackitt's residence. The dog alerted to the presence of drugs in the vehicle. The officer checked Tackitt's criminal record and verified some of the public information received in the tip and then obtained a warrant to search the vehicle and Tackitt's residence. The vehicle search revealed no evidence, but during the search of the residence, officers found drugs and paraphernalia. Tackitt moved to suppress on grounds that use of the dog violated the right to privacy. The District Court denied the motion, holding that Tackitt had no reasonable expectation of privacy in the odors emanating from his vehicle while it was parked in an area open to the public or, alternatively, that if
partialized suspicion was required for use of the dog, the search in this case was supported by proper partialized suspicion. Tackitt appealed, and the Supreme Court reversed. Pursuant to St. v. Elison, 2000 MT 288, 302 M 228, 14 P3d 456 (2000), Tackitt had an expectation of privacy in the trunk of the vehicle, and the canine sniff did constitute a search. However, the expectation was in no way dependent on where the vehicle was parked, nor did the expectation necessitate a search warrant for the use of the canine to survey the exterior of the vehicle. Federal law allows the use of drug-detecting dogs to sniff closed containers in public areas when police have a partialized suspicion to believe that a crime involving drugs is taking place. Under the greater protection afforded individual privacy under the Montana Constitution, the balance between governmental interests and individual interests is best struck by requiring partialized suspicion as a prerequisite for the use of a drug-sniffing dog. Partialized suspicion must be based on objective data from which an experienced police officer can make the inference that a person is engaged in wrongdoing, and an anonymous tip lacking appropriate corroboration simply cannot qualify as objective data to support a partialized suspicion any more than it can support probable cause. Therefore, because the District Court improperly concluded that there was a partialized suspicion for use of the dog to survey the exterior of Tackitt's vehicle and because the application for the search warrant failed to establish probable cause for the issuance of the warrant, the District Court's denial of the motion to suppress was reversible error. (Note: this holding is limited to the use of drug-sniffing dogs during police investigations and does not apply to the human detection of the odor of drugs.) St. v. Tackitt, 2003 MT 81, 315 M 59, 67 P3d 295 (2003), distinguishing St. v. Scheetz, 286 M 41, 950 P2d 722 (1997).

Reasonable Expectation of Privacy in Lost Wallet -- Evidence Obtained From Search of Lost Wallet Subject to Suppression: Hamilton's lost wallet was turned into the Bozeman police, who opened it to determine ownership. In doing so, the police discovered prescription drugs. Hamilton confessed that the drugs were not prescribed for her, and she was arrested and convicted. On appeal, Hamilton asserted that she retained an expectation of privacy in the lost wallet and that the fruits of the search of the wallet should be suppressed. The Supreme Court agreed. In determining whether an unlawful search of the wallet occurred, the court applied St. v. Scheetz, 286 M 41, 950 P2d 722 (1997), looking at whether Hamilton had an actual expectation of privacy that society was willing to recognize as objectively reasonable and at the nature of the state's intrusion. When a person intentionally abandons property, the expectation of privacy is abandoned as well. However, when property is not intentionally or voluntarily abandoned, the expectation of privacy remains substantially intact. Thus, Hamilton's expectation of privacy was diminished only to the extent necessary for the police to determine ownership. The police search exceeded what was necessary to determine ownership of the wallet and was not justified by any exception to the warrant requirements. Therefore, the warrantless search was illegal, and the evidence obtained as a result of the search should have been suppressed. Hamilton's conviction was reversed. St. v. Hamilton, 2003 MT 71, 314 M 507, 67 P3d 871 (2003).

Evaluation of Reliability of Confidential Tip -- Unreliable Tip as Only Grounds for Investigative Stop -- Infringement of Right to Privacy: Following weeks of surveillance instigated by a confidential tip intimating drug activities, the Billings police observed no suspicious drug-related activities conducted by defendants, but after receiving a confidential tip that defendants would be driving from Billings to Bozeman to sell marijuana, officers stopped and searched defendants' vehicle and arrested defendants for drug possession. Defendants contended that insufficient objective data inferring criminality existed to justify the investigatory stop. The Supreme Court applied the analysis in St. v. Pratt, 286 M 156, 951 P2d 37 (1997), to evaluate the reliability of the informant's tip. The court distinguished between a concerned citizen who reports a chance encounter with crime as a civic duty and a confidential informant who works with police by reporting on the illegal activities of others. A citizen informant is presumed to be telling the truth, but a confidential informant does not enjoy the same presumption of veracity. Further, for a tip to support a finding of probable cause, police must know the identity of the informant, trust from experience or presumption that the informant is telling the truth, and discern that the informant's information about the alleged crime derives from the informant's personal observations. Officers must then evaluate the veracity, reliability, and basis of knowledge of the informant to determine whether the report supports reasonable suspicion. If a tip is anonymous and lacks any indication of the basis for the informant's opinion, the tip must be corroborated through the observation of suspicious activity that alerts officers to the possibility of a violation. Corroboration of a tip.
with innocent information may lend an unknown or untested tipster some credibility, but this indicia of reliability does not obviate the relevance of the tipster's basis of knowledge as a factor in the evaluation. In the context of particularized suspicion, because the quantum of suspicion is less, an unreliable tip requires corroboration that supports an inference of criminality by direct police observation of suspicious activity and consideration of the modes of patterns of operation of certain kinds of lawbreakers, and mere police corroboration of innocent facts is insufficient. Here, defendants engaged in no observed criminal activity, and their travel plans were equally consistent with innocent behavior. Although the traffic stop was initially made to check a temporary sticker on the vehicle, once the sticker was found to be valid, grounds for the stop ended and no further police intrusion was warranted. St. v. Martinez, 2003 MT 65, 314 M 434, 67 P3d 207 (2003), following St. v. Henderson, 1998 MT 233, 291 M 77, 966 P2d 137 (1998), and distinguishing Ala. v. White, 496 US 325 (1990). See also St. v. Reesman, 2000 MT 243, 301 M 408, 10 P3d 83 (2000).

Unusual but Legal Driving and Unsupported Tip Insufficient Grounds for Particularized Suspicion to Make Investigative Stop: An officer received a tip concerning suspicious activity in a high crime area of Billings. The officer observed Fisher's car in the area and followed the car. The officer observed that the vehicle had a temporary sticker, which could not be read, but no license plate. The vehicle made several turns and ended up on the street where the officer originally saw it. The officer then stopped the vehicle, and Fisher was subsequently arrested for possession of drugs and drug paraphernalia. Fisher moved to suppress the evidence on grounds that the officer had no particularized suspicion to make the stop. The motion was denied and Fisher was convicted and appealed. The state initially claimed that the officer had a particularized suspicion that Fisher was in violation of vehicle registration laws, but the state waived that argument when the officer testified to that effect. Further, none of the information in the anonymous tip was connected to Fisher; rather, the officer stated that he wanted to obtain the identity of the vehicle occupants for later investigation of the tip. However, under St. v. Anderson, 258 M 510, 853 P2d 1245 (1993), an investigative stop is not justified in order to corroborate a tip. Lastly, Fisher maintained an appropriate speed, violated no traffic laws, and made no unusual turns, and Fisher's driving was not headlong flight or evasive. The simple fact that Fisher drove back to the original street where the officer saw the vehicle, absent more objective data, was insufficient for the officer to form a particularized suspicion that Fisher was engaged in criminal activity based on operation of the vehicle. Thus, the stop violated Fisher's right to be free from unreasonable search and seizure and the Supreme Court reversed. St. v. Fisher, 2002 MT 335, 313 M 274, 60 P3d 1004 (2002), distinguishing St. v. Henderson, 1998 MT 233, 291 M 77, 966 P2d 137 (1998), and Ill. v. Wardlow, 528 US 119 (2000).

Involuntary Written Consent to Search -- Suppression of Illegally Seized Evidence Under Exclusionary Rule: Olson was arrested when officers entered her home pursuant to a warrant for Olson's failure to appear at a Justice's Court hearing. While the arrest was taking place in the kitchen, an officer looked into the living room and observed drug paraphernalia. Officers then searched other rooms of the house and found drugs and paraphernalia in each room. An officer requested that Olson sign a form consenting to a further search of the residence, and Olson agreed. A further search revealed more drugs and paraphernalia. Olson later made a taped statement in jail. The District Court denied Olson's motion to suppress on grounds that there was no voluntary consent to search the residence. The Supreme Court disagreed and reversed. Although the knowing and voluntary consent by a citizen to a search is a recognized exception to warrant requirements, consent is not voluntary when it is given only after law enforcement officers have already conducted an illegal search because the consent flows directly from the unlawful intrusion. Further, the taped statement should have also been suppressed under the exclusionary rule, because the incriminating statement was gathered as a result of the unlawful search. St. v. Olson, 2002 MT 211, 311 M 270, 55 P3d 935 (2002).

Warrantless Search of Home Subsequent to Lawful Arrest Unjustified Under Plain View Doctrine and Protective Sweep: Olson was arrested when officers entered her home pursuant to a warrant for Olson's failure to appear at a Justice's Court hearing. While the arrest was taking place in the kitchen, an officer looked into the living room and observed drug paraphernalia. Officers then searched other rooms of the house and found drugs and paraphernalia in each room. Olson moved to suppress the evidence and subsequent statement on grounds that the warrantless search was unreasonable. The District Court denied the motion pursuant to the plain view doctrine and concluded that the search was justified as a precautionary sweep. The Supreme Court reversed.
Under *Chimel v. Calif.*, 395 US 752 (1969), there is no comparable justification for routinely searching any room other than that in which the arrest occurs. Further, under *Md. v. Buie*, 494 US 325 (1990), a protective sweep is justified when there are articulable facts that, taken together with the rational inferences from those facts, warrant a reasonably prudent officer in believing that the area to be swept harbors an individual posing a danger to those on the arrest scene. In this case, the arresting officers were informed that there was no one else in the house at the time of the arrest and had no indication to believe otherwise. Neither the plain view doctrine nor a protective sweep justified a further search of the residence without a warrant. St. v. Olson, 2002 MT 211, 311 M 270, 55 P3d 935 (2002).

**Absence of Exigent Circumstances -- Warrantless Search Unjustified:** Logan was one of two passengers in a vehicle that was stopped for failure to have the rear license plate illuminated. The officer recognized the driver, who had a history of carrying weapons and of violence toward police officers, and called for backup. The officer then approached the vehicle but did not smell or observe any illegal drugs or drug paraphernalia or observe any behavior that led the officer to believe that anyone in the vehicle was under the influence of drugs. After obtaining identification from the driver and passengers, the officer ran a check for outstanding warrants on all the parties and learned that all three persons had past drug arrests and that an extreme officer caution alert was in effect for the driver. The officer then called for another officer who had a drug-sniffing dog. The dog alerted to the passenger-side door of the car, and the officer removed a purse from the back seat containing drug paraphernalia and a paper bindle. The dog entered the vehicle and indicated additional drugs. Logan was subsequently arrested for possession of dangerous drugs but moved to suppress the evidence on grounds that the officer did not have a particularized suspicion of the presence of drugs to support a canine sniff search of the vehicle. The Supreme Court agreed. In St. v. Elison, 2000 MT 288, 302 M 228, 14 P3d 456 (2000), the Supreme Court held that there is no automobile exception to constitutional search warrant requirements and that the mobility of a vehicle, without more, is not sufficient to justify a warrantless search. In addition to particularized suspicion, a warrantless search of a vehicle requires probable cause and a generally applicable exception to the warrant requirement, such as plain view search, a search incident to arrest, or exigent circumstances, which was the only applicable exception at issue here. The District Court held that the exigent circumstance in this case was that allowing Logan to reenter the vehicle to retrieve the purse would have provided the opportunity to destroy the evidence. However, the officer testified that there was nothing that prevented obtaining a search warrant, and that testimony itself belied the fact that exigent circumstances existed. Because the state failed to meet the heavy burden of proving exigent circumstances, the District Court erred in denying Logan's motion to suppress, so the case was reversed. St. v. Logan, 2002 MT 206, 311 M 239, 53 P3d 1285 (2002).

**Elements of Community Caretaker Doctrine -- Particularized Suspicion Not Required in Case of Safety Stop:** About 3:05 a.m., an officer on routine patrol stopped to investigate a vehicle parked beside a highway with its lights out but with its motor running. Lovegren was in the driver's seat and appeared to be asleep, but he did not respond when the officer knocked on the window. When the officer opened the door, Lovegren awoke and stated, "I was drinking." The officer noticed that Lovegren's eyes were bloodshot and smelled alcohol. The officer had Lovegren perform field sobriety tests, which Lovegren failed, and arrested Lovegren for DUI. Lovegren moved to suppress all evidence, claiming that the search was illegal because the officer had no particularized suspicion of any wrongdoing. The District Court denied the motion on grounds that a particularized suspicion was not necessary because the officer had a duty to investigate for Lovegren's own safety. Lovegren appealed, but the Supreme Court affirmed pursuant to the community caretaker doctrine. The court applied the following test to determine whether an officer's actions fall under the doctrine: (1) as long as there are objective, specific, and articulable facts from which an experienced officer would suspect that a citizen is in need of help or is in peril, the officer has a right to stop and investigate; (2) if the citizen is in need of aid, the officer may take appropriate action to render assistance or mitigate the peril; and (3) once the officer is assured that the citizen is not in peril and is not in need of assistance or that the peril has been mitigated, any actions beyond that constitute a seizure implicating constitutional protections afforded by the right of privacy and the right against illegal search and seizure. In this case, when the officer opened the door to check on Lovegren's well-being and Lovegren awoke and voluntarily stated that he had been drinking, the officer then noticed other signs of intoxication that constituted a particularized
suspicion to make a further investigative stop that eventually developed into probable cause for an arrest. It would have been a dereliction of the officer's duty if, after knocking on the window and receiving no response, the officer had walked away and continued on patrol. Thus, the escalation of events leading to Lovegren's arrest was proper, and denial of the motion to suppress the evidence of the investigation was not erroneous. St. v. Lovegren, 2002 MT 153, 310 M 358, 51 P3d 471 (2002), following Grinde v. St., 249 M 77, 813 P2d 473 (1991), and Hulse v. St., 1998 MT 108, 289 M 1, 961 P2d 75 (1998). See also Henry v. U.S., 361 US 98 (1959), Terry v. Ohio, 392 US 1 (1968), and Cady v. Dombrowski, 413 US 433 (1973).

No Reasonable Expectation of Privacy in Possession of Game Fish -- Probable Cause Not Required for Game Warden's Inspection of Angler's Concealed Catch: Initially concerned for the safety of the occupants of a seemingly unoccupied watercraft, a game warden approached the watercraft. When informed that Boyer had been fishing, the warden asked to see Boyer's license and catch. After Boyer requested a later inspection, he reluctantly exhibited eight fish. At that point, the warden looked into the live well of Boyer's boat, and in the process found unlawfully killed game fish. Boyer contended that the warden needed probable cause to believe that Boyer had committed a violation at the time that the request was made in order to inspect his catch, and that conducting a warrantless search of Boyer's live well was impermissible. The Supreme Court noted that under the Montana Constitution, an impermissible search occurs only when a reasonable expectation of privacy exists. To determine whether the warden unlawfully intruded into Boyer's privacy, the court considered: (1) whether Boyer had an actual expectation of privacy; (2) whether society was willing to recognize that expectation as objectively reasonable; and (3) the nature of the state's intrusion (see St. v. Bassett, 1999 MT 109, 294 M 327, 982 P2d 410 (1999)). The court concluded that Boyer's subjective expectation of privacy in his catch was not one that society would recognize as reasonable. Under Art. IX, sec. 1, Mont. Const., the state must maintain a clean and healthful environment, and the Legislature has provided for game wardens to enforce the environmental laws regarding fish and game by implementing a system that includes the ability of wardens to inspect game in the field, which encompasses proper licensing and game limitation requirements. In this capacity, wardens act as public trustees protecting and conserving Montana wildlife and habitat for all citizens. Fishing is a privilege accorded by the state, not a private right, and anglers must assume the burdens of the sport, as well as its benefits, and acknowledge the prospect of at least some governmental intrusion into their activities, including license checks, inquiries about game taken, and requests to inspect game in the field. Because Boyer had no reasonable expectation of privacy in his catch, the warden's request for and inspection of the catch was not considered a search, so probable cause was not necessary. St. v. Boyer, 2002 MT 33, 308 M 276, 42 P3d 771 (2002).

Invalid Warrantless Search of Defendant's Hands Absent Exigent Circumstances: Officers responding to a break-in found blood on doorknobs, light switches, broken glass, and other objects in the house and garage. Matching the description of the suspect, Hardaway was picked up near the scene and found to have blood on his hands. Hardaway was arrested for burglary, and during postarrest processing, blood was swabbed from his hands without permission or a warrant. The blood sample matched the blood evidence found at the scene. Hardaway moved to suppress blood swab evidence obtained from his hands after arrest, but the motion was denied. The District Court reasoned that the swabbing either was not a search, pursuant to St. v. Holzapfel, 230 M 105, 748 P2d 953 (1988), or was justified as a search incident to arrest, pursuant to St. v. Ulrich, 187 M 347, 609 P2d 1218 (1980). Hardaway appealed on grounds that the swabbing was clearly a search that was required to be justified by both probable cause and exigent circumstances and that no exigent circumstances existed because he was in custody at the time and a warrant could have been obtained. The Supreme Court agreed and reversed. The court adopted the analysis of what constitutes a search set out in Cupp v. Murphy, 412 US 291 (1973), holding that Hardaway had a reasonable expectation of privacy as to his person and personal security (overruling Holzapfel) and that the swabbing constituted a search subject to federal and Montana constitutional protections. Although his hands and the blood on them were exposed to the public for viewing, it was not the viewing that constituted a search, but rather the swabbing. Further, even though the swabbing could be considered a search incident to arrest pursuant to federal law and the bright-line rule in U.S. v. Robinson, 414 US 218 (1973), that requires no further justification than a lawful arrest for the search exception to apply, the Supreme Court opted to grant greater individual privacy rights protection to Hardaway based on the Montana Constitution, consistent with the prior holding in St. v. Sawyer, 174 M 512, 571 P2d 1131
control of the police, with no present means of preventing an arrestee from using any weapons, escaping, or destroying incriminating evanescent evidence in the arrestee's possession, considered inherently anticipated exigent circumstances under 46-5-102(1) through (3); however, to the extent that a warrantless search incident to a lawful arrest is conducted pursuant to 46-5-102(4), which deals with discovering and seizing any persons, instruments, articles, or things that may have been used in the commission of or that may constitute evidence of the offense, specific and articulable exigent circumstances are also required to justify and render the search lawful (distinguishing and partially overruling Ulrich). Here, there were simply no exigent circumstances requiring a warrantless search. Hardaway was at the station house, under the full control of the police, with no present means of destroying the blood evidence. Hardaway could have consented to the swab or waited in discomfort until a warrant was obtained, but either way the evidence was going nowhere. Therefore, the swabbing of Hardaway's hands was not a valid search incident to arrest. St. v. Hardaway, 2001 MT 252, 307 M 139, 36 P3d 900 (2001).

**Arrest and Detention for Nonjailable Offense Unreasonable Absent Circumstances to Justify Immediate Arrest:** A Havre police officer responded to a 2:47 a.m. complaint that two people were "messing around with cars" and were running toward the post office, but no physical description was provided. While searching the post office area, the officer noticed a person walking down the street. Upon seeing the police car, the person began running. Bauer was eventually found and arrested for minor in possession (MIP), second offense. During booking, Bauer was also found to be in possession of drugs, but moved to suppress on grounds that his arrest and detention for a nonjailable offense was an unlawful violation of the right to privacy, the right to be free from unreasonable search and seizure, and the right to be free from cruel and unusual punishment. The District Court concluded that the arrest was lawful because once the officer had probable cause to arrest, the right to detain was inherent. The Supreme Court disagreed, reversed, and suppressed the fruits of the search. When determining the reasonableness of a warrantless search, the state's interest must be balanced against the level of intrusion into an individual's privacy resulting from the search, and this analysis applies equally to the seizure of a person. Although 46-6-311 gives officers the discretion to either arrest or issue a notice to appear, to be constitutional, the officer's exercise of that discretion must be reasonable, and in addition to probable cause, there must also be circumstances that require immediate arrest. It is unreasonable for an officer to effect an arrest and detention for a nonjailable offense when there are no circumstances to justify an immediate arrest, and a person stopped for such an offense should not be subjected to the indignity of an arrest and police station detention when a simple, nonintrusive notice to appear will serve the interests of law enforcement. Here, the officer knew that imprisonment was not a potential punishment for Bauer's second offense MIP, and there were no circumstances that required Bauer's immediate arrest, so Bauer should have been issued a notice to appear in lieu of arrest. St. v. Bauer, 2001 MT 248, 307 M 105, 36 P3d 892 (2001).

**Exigency Requirements for Warrantless Search of Vehicle Clarified -- Automobile Exception to Search Warrant Requirement Inapplicable:** In order to justify the warrantless search of an automobile, the state must show exigent circumstances under which it was not practical to obtain a warrant. Taking the opportunity to clarify the source of the exigency requirement, the Supreme Court noted that Montana's unique constitutional language affords citizens a greater right to privacy and broader protection than the federal constitution in cases involving searches of private property, and as a result, the category of warrantless searches that may be conducted under the Montana Constitution is narrower than the category of warrantless searches that may be conducted under the federal constitution. The Montana Constitution provides greater protection from warrantless search of automobiles, and such searches are restricted to the purpose of safeguarding articles within plain view of the officer. In this case, Elison had items stowed out of view behind the seat of his car, creating an actual and reasonable expectation of privacy, and the state needed a compelling interest beyond the mere existence of probable cause to search the car without a warrant. The warrantless search of an automobile also requires the existence of a generally applicable exception to the warrant requirement, such as a plain view search, a search incident to arrest, or exigent circumstances. Here, the District Court found exigent circumstances, including the mobility of the vehicle, the possibility that a confederate could move the vehicle, and the fact that it would have been difficult to obtain a warrant at the time that the stop was made at 12:05 a.m. The Supreme Court disagreed and held that the state failed to carry the heavy burden of proving exigent circumstances. Mere mobility of a
vehicle, without more, is insufficient to justify a warrantless search. The possibility that a confederate could move the vehicle did not apply because Elison was alone and without means to contact a confederate. The validity of a warrantless search also does not turn solely on the time of day that the search is conducted. Although Montana magistrates may prefer not to be disturbed late at night, Montana's constitutional protections apply at all times and do not simply fade away with the setting sun. Absent exigency, the search of Elison's vehicle was unlawful, and Elison's motion to suppress the fruits of the warrantless search was improperly denied. The case was reversed. St. v. Elison, 2000 MT 288, 302 M 228, 14 P3d 456, 57 St. Rep. 1206 (2000).

Entry of Intensive Supervision Program Officer Into Probationer's Home Without Consent Unlawful - Information Gathered Via Search Admissible as Independent Source or Inevitable Discovery Exceptions to Fruit of Poisonous Tree Doctrine: As a condition of suspended sentencing, Therriault was placed in the intensive supervision program (ISP). Near the end of the program, Therriault's supervising officer, McCarty, arrived at Therriault's residence for a routine check. Although Therriault was not there, McCarty entered the residence and found, in plain view, what he thought might be a note for him from Therriault, but which turned out to be a high school registration form for a female student. McCarty then went to Therriault's sister's home next door. Therriault's sister informed McCarty that she had seen a girl at Therriault's home during the prior 2 weeks and inquired about the lawful age of consent. McCarty reentered Therriault's home and reviewed the form, discovering that the applicant was 14 years old. McCarty left a note for Therriault to contact him and left the residence but returned later that night to discover a 14-year-old girl in Therriault's basement. Upon petition to revoke his probation, Therriault alleged that the discovery directly resulted from an illegal search and seizure and moved to suppress all evidence under the fruit of the poisonous tree doctrine. The District Court denied the motion, revoked Therriault's suspended sentence, and sentenced him to prison for the remainder of the term. Therriault appealed. The state contended that as a participant in ISP, Therriault enjoyed little or no expectation of privacy and that McCarty's conduct did not constitute a search. The Supreme Court disagreed, finding that ISP is merely a rigid condition imposed on certain probationers and that it is the sentencing tribunal, not the ISP officer, that establishes the conditions for any search of the probationer's person or property and that any ISP rules, terms or conditions, or means of supervision that conflict with a court-ordered condition of probation will be superseded by the court's conditions. The state misconstrued Therriault's expectation of privacy under ISP because the court's probationary condition stated that Therriault would submit his residence "to search at any time by lawful authorities upon reasonable request of his Probation Officer", so Therriault could expect that an intrusion into the privacy of his home would not occur unless McCarty had reasonable cause and first posed a reasonable request. Accordingly, McCarty's conduct constituted an illegal search and evidence obtained through the unlawful conduct would not generally be admissible under the fruit of the poisonous tree doctrine. However, under St. v. New, 276 M 529, 917 P2d 919 (1996), such derivative evidence is admissible if it is: (1) attenuated from the constitutional violation so as to remove its primary taint; (2) obtained from an independent source; or (3) determined to be evidence that would have been inevitably discovered apart from the constitutional violation. In this case, the second exception applied. McCarty received independent incriminating evidence from Therriault's sister; thus, it was not the tainted evidence of the girl's name or age or the fact that she was transferring to a different school that led to her discovery, but rather the independent information that a girl of questionable age had been residing with Therriault. This irrefutable evidence, ascertained through a source sufficiently independent of McCarty's unlawful conduct, warranted exclusion from the fruit of the poisonous tree doctrine. The District Court's revocation of Therriault's suspended sentence was affirmed. St. v. Therriault, 2000 MT 286, 302 M 189, 14 P3d 444, 57 St. Rep. 1185 (2000).

Traffic Stop of Illegally Operated Vehicle Not Considered Pretext for Search of Vehicle for Narcotics: Officers conducting surveillance of a house where drug activities were suspected noticed that a vehicle leaving the area was missing a headlight. The officers believed that the driver, Farabee, may have just completed a drug transaction at the house and pulled over the vehicle, based on the fact that the vehicle appeared to be in violation of 61-9-104, which requires two working headlights. Upon receiving permission and searching the vehicle, the officers discovered marijuana and paraphernalia. On appeal, Farabee argued that the evidence should be suppressed because the officers used the equipment violation as a pretext to stop him and investigate their hunch, in violation of section 11. The Supreme Court disagreed, applying
the rationale in Whren v. U.S., 517 US 806 (1996), that an officer's motive for a traffic stop does not render an objectively reasonable stop invalid. The constitutional reasonableness of a traffic stop does not depend on the subjective motivations of the individual officers involved. In this case, based on the objective and particularized data that the vehicle appeared to be missing a headlight, the officers made the reasonable inference that the headlight was inoperable, so the totality of the circumstances justified the investigative stop. Farabee's motion to suppress was properly denied. St. v. Farabee, 2000 MT 265, 302 M 29, 22 P3d 175, 57 St. Rep. 1106 (2000), distinguishing St. v. Lahr, 172 M 32, 560 P2d 527 (1977).

Warrantless Strip Search of Prison Visitor Permissible if Supported by Reasonable Suspicion: Deserly traveled to the state prison to visit her husband who was an inmate, but upon attempting to enter, her underwire bra set off the metal detector. She was informed that she could consent to a strip search and that if she refused, she would be denied contact visitation but would be allowed noncontact visitation. Deserly was a former jailer and knew what a strip search entailed, but nevertheless consented to the search. Later, Deserly sued the Department of Corrections, seeking unspecified damages for emotional distress allegedly caused when the prison officers required her to submit to the strip search, complaining that her privacy was invaded and that she was humiliated and visually raped as a result of the search. The District Court found that the search was justified and that no privacy invasion occurred and summarily dismissed the case. Deserly conceded on appeal that because the state has an interest in the security of its penal institutions, searches of inmate visitors are justifiable only on satisfying a reasonable suspicion standard, but maintained that the legitimate penological need to conduct the search could have been satisfied by more narrow means than a strip search. The Supreme Court acknowledged that one of the clearest forms of degradation in Western society is to strip a person of the person's clothes and that a strip search, regardless of how professionally and courteously conducted, is an embarrassing and humiliating experience. Further, a prison visitor retains the constitutional right to be free from unreasonable searches and seizures. However, a prison visitor does not have a due process right to unfettered visitation, nor does a citizen have a right to unfettered visitation of a prisoner that rises to a constitutional dimension. Moreover, in seeking entry into a controlled prison environment, a visitor simultaneously acknowledges a lesser expectation of privacy because of the insistence on access. Because prisons are dangerous places for employees, visitors, and inmates, the basic constitutional issue becomes one of balancing the legitimate governmental interest in and need for searching inmate and prison visitors against the intrusions into personal rights and residual privacy interests that such searches entail. Although prison visitors can be subjected to some searches, such as pat-downs or metal detector sweeps, merely as a condition of visitation, more intrusive searches,
such as strip searches, are permissible as exceptions to the constitutional warrant requirements only if the search is supported by reasonable suspicion. Thus, the ultimate question was not simply whether there was some alternative means of conducting the search, but whether prison officials acted reasonably and used the least intrusive means under the circumstances. In Deserly's case, the strip search was supported by reasonable suspicion and was conducted in a manner that took into account Deserly's privacy interest and yet fulfilled the Department's penalogical need to ensure that Deserly was not carrying metal contraband in some article of her clothing. Deserly v. Dept. of Corrections, 2000 MT 42, 298 M 328, 995 P2d 972, 57 St. Rep. 199 (2000), following St. v. Bassett, 1999 MT 109, 294 M 327, 982 P2d 410, 56 St. Rep. 447 (1999), and distinguishing Hunter v. Auger, 672 F2d 668 (8th Cir. 1982), and Thorne v. Jones, 765 F2d 1270 (5th Cir. 1985).

Lack of Evidence That Investigating Officers Went Above High-Water Mark to Obtain Photograph of Marijuana Plant on Private Property -- Motion to Suppress Properly Denied: An anonymous caller informed the Rosebud County Sheriff's office that Mogen was growing marijuana on Mogen's private land abutting the Yellowstone River. A Sheriff's officer and a game warden traveled by boat down the river to begin surveillance operations. The officers did not have a search warrant or permission to be on Mogen's property, nor was the property posted along the river. The Sheriff testified that the game warden came along to identify and prevent trespass above the ordinary high-water mark, below which public access is allowed pursuant to Mont. Coalition for Stream Access, Inc. v. Curran, 210 M 38, 682 P2d 163, 41 St. Rep. 906 (1984). The officers used binoculars to view the suspected marijuana plant and took photographs of the plant from a point that they testified was below the ordinary high-water mark. Mogen moved to suppress the evidence, asserting that the officers must have crossed above the ordinary high-water mark, without an invitation or warrant, to observe and take the photographs in a portion of his property where he had an expectation of privacy and that the evidence was thus illegally seized. The District Court denied the motion to suppress. The Supreme Court affirmed, finding nothing in the record to indicate that the District Court's finding of fact was clearly erroneous or incorrectly applied. St. v. Mogen, 2000 MT 14, 298 M 87, 993 P2d 699, 57 St. Rep. 82 (2000), following St. v. Siegal, 281 M 250, 934 P2d 176, 54 St. Rep. 158 (1997).

Invalid Third-Party Consent to Warrantless Search of Private Residence -- Consenting Party to Have Actual Authority to Consent to Search: A warrantless search conducted inside a home is per se unreasonable, subject to only a few exceptions, one of which is when the search is conducted pursuant to consent that is freely and voluntarily given. The state may justify a warrantless search by showing that permission was obtained from defendant or from a third party who possessed common authority over or other sufficient relationship to the premises or effect sought to be inspected, but the state has the burden of showing that consent was voluntary. However, for third-party consent to be valid, the consenting party must have actual authority to consent, as opposed to apparent authority. In the present case, McLees lived with his father, Scott, in an apartment owned by his grandfather, Earl, and investigating officers obtained Earl's voluntary consent before searching the residence. The District Court held that Earl had common authority to consent to the search and denied McLees' motion to suppress incriminating evidence found in the search. The Supreme Court disagreed. Under U.S. v. Matlock, 415 US 164, 39 L Ed 2d 249, 94 S Ct 988 (1974), common authority may not be implied from the mere property interest of a third party in the property to be searched. Rather, the authority that justifies third-party consent rests on the mutual use of the property by persons having joint access or control for most purposes. Here, the record was insufficient to show that Earl had common authority over McLees' apartment. Earl never went to the apartment unless Scott was there. Earl did not have free access to and was not a cohabitant of the apartment and did not share in its use. The fact that Earl owned the property was not dispositive when McLees had a reasonable expectation of privacy by living there. Earl therefore did not have a sufficient relationship with the apartment that would give him actual authority to consent to a warrantless search. While declining to address whether the seized evidence was admissible under the independent source rule or the inevitable discovery rule, the Supreme Court held that it was inadmissible under the third-party consent rule and reversed for further proceedings. St. v. McLees, 2000 MT 6, 298 M 15, 994 P2d 683, 57 St. Rep. 25 (2000), following St. v. Sorenson, 180 M 269, 590 P2d 136 (1979), St. v. Lopez, 896 P2d 889 (Hawaii 1995), and St. v. Hubbel, 286 M 200, 951 P2d 971, 54 St. Rep. 1373 (1997), and distinguishing Ill. v. Rodriguez, 497 US 177, 111 L Ed 2d 148, 110 S Ct 2793 (1990).

Lawful Entry Into Home by Firefighter --

Reasonable Expectation of Privacy Retained -- Plain View Exception Inapplicable: A firefighter legally in Bassett's home performing mop up after a fire discovered apparent marijuana growing in a closet. The plants, visible because the closet door had burned away, were subsequently seized by a Deputy Sheriff without a warrant. When told that the plants had been discovered, Bassett waived Miranda rights and admitted growing marijuana but later moved to suppress the statement because it was the direct product of an unconstitutional search. The District Court admitted evidence from the search under the plain view exception and denied suppression of Bassett's confession. The court further held that Bassett no longer held a reasonable expectation of privacy in his closet because he did nothing to restrict entry into the home and because society would not view entry into a burned residence that was largely destroyed and open to the elements as an invasion of privacy. To determine the threshold question of whether the search was an unlawful intrusion into Bassett's privacy, the Supreme Court applied the criteria in St. v. Hubbel, 286 M 200, 951 P2d 971, 54 St. Rep. 1373 (1997): (1) whether Bassett had an actual expectation of privacy; (2) whether society would recognize that expectation as objectively reasonable; and (3) the nature of the state's intrusion. Citing Mich. v. Tyler, 436 US 499, 56 L Ed 2d 486, 98 S Ct 1942 (1978), the court noted that a person retains a reasonable privacy interest in that person's home even when it has been damaged by fire. The court also followed U.S. v. Hoffman, 607 F2d 280 (9th Cir. 1979), for the proposition that the privacy expectation remains even when firefighters discover contraband. Although a firefighter is obviously justified and in fact expected by Montanans to enter a home to extinguish a fire, this does not mean that Montanans reasonably expect that the private sanctity of their homes will then be open to other government officials to search for evidence of unrelated criminal activity simply because the firefighter was already legitimately on the premises. The firefighter and the Deputy Sheriff each had separate reasons for entering the home. Therefore, two entirely separate justifications for each entry were required. There was no exigent circumstance, such as an immediate emergency, that justified the Deputy Sheriff's warrantless entry, nor did the plain view exception apply because the officer was not legally in the home when the evidence was seen. Further, Bassett did not need to take any affirmative steps to demonstrate that he retained his privacy interest. The warrantless search was unjustified, and Bassett's incriminating statement was the direct product of an illegal search and thus inadmissible by virtue of the exclusionary rule. St. v. Bassett, 1999 MT 109, 294 M 327, 982 P2d 410, 56 St. Rep. 447 (1999), distinguishing St. v. Bell, 737 P2d 254 (Wash. 1987), and St. v. Loh, 275 M 460, 913 P2d 592, 53 St. Rep. 226 (1996), and followed in Deserly v. Dept. of Corrections, 2000 MT 42, 298 M 328, 995 P2d 972, 57 St. Rep. 199 (2000).

Discovery of Shotgun Case During Routine Walk-Through of Probationer's Residence Constituting Reasonable Grounds for Further Warrantless Search: Probationer Stucker allowed a voluntary tour of his residence by probation officers, who discovered two weapons cases in plain view in the master bedroom. One case contained a bow, which Stucker was allowed to possess under the terms of his probation; the other contained a semiautomatic shotgun, which constituted contraband under the probation conditions. The discovery of the shotgun case in plain view constituted reasonable grounds for the officers to conduct a warrantless search of the residence to determine if additional weapons were present. The District Court did not err in denying Stucker's motion to suppress the fruits of the search. St. v. Stucker, 1999 MT 14, 293 M 123, 973 P2d 835, 56 St. Rep. 65 (1999).

Enforceability of Civil Judgment Insufficient Compelling State Interest to Justify Warrantless Search of Judgment Debtor's Residence: Police officers searched Dorwart's home pursuant to writs of execution and seized his personal property, but without Dorwart's permission or a search warrant. The argument was made that the compelling state interest justifying the warrantless search and seizure was the enforcement of monetary judgments by the seizure of the judgment debtor's property and the preservation of the credibility of the judicial system. Although the Supreme Court has held that a compelling state interest justifying an intrusion into a person's privacy may exist when the state is acting to enforce its criminal laws or to protect society in general from the actions of criminal wrongdoers, but rather for the purpose of enforcing a civil judgment between two private citizens. The state's interest in postjudgment execution cases is not so compelling as to justify an intrusion into a person's private home, without the person's consent, for purposes of searching that home and seizing any property that might have some value. Dorwart v. Caraway, 1998 MT 191, 290 M 196, 966 P2d 1121, 55 St. Rep. 777 (1998).
Entry of Residence to Levy Upon Personal Property While Judgment Debtor Incarcerated -- Entry and Search of Private Home Not Authorized by Writ of Execution: Dorwart was named defendant in two small claims actions, resulting in the entry of default judgments against him and the issuance of writs of execution to enforce the judgments. About 1 month later, while driving his truck, Dorwart was stopped and served with the two writs and was subsequently also arrested for driving under the influence and incarcerated. While Dorwart was in jail, two Sheriff's deputies entered Dorwart's home and garage without his permission or a warrant and seized various items of personal property pursuant to the writs, relying on the writs as the sole authority for authorization to enter the residence and conduct the search and seizure. Dorwart later filed a complaint, alleging various state and federal claims and common-law tort claims and contending that Montana's postjudgment execution statutes are unconstitutional. The District Court found that the deputies did not violate Dorwart's constitutional right to be free from unreasonable search and seizure because the writs constituted judicial authorization for their actions. On appeal, the prosecution relied on Ramsey v. Burns, 27 M 154, 69 P 711 (1902), for the proposition that one of the implied powers authorized by a writ of execution includes the levying officer's entry into a judgment debtor's residence or place of business in order to execute the writ and that on that basis, entry of the home was not unreasonable. The Supreme Court distinguished Ramsey because no constitutional search and seizure issue was raised in that case. Dorwart had a legitimate expectation of privacy in his home, and government intrusion without a search warrant was per se unreasonable, subject to only a few exceptions that did not apply. Citing Camara v. Municipal Court, 387 US 523, 18 L Ed 2d 930, 87 S Ct 1727 (1967), and G.M. Leasing Corp. v. U.S., 429 US 338, 50 L Ed 2d 530, 97 S Ct 619 (1977), the court found that the constitutional prohibition against unreasonable search and seizure applies in civil as well as criminal contexts because all citizens have a strong interest in securing their homes from government intrusion, regardless of the reason for the intrusion, and that placing limitations on the discretion of when, where, and how to conduct a search that intrudes upon a private area is the precise reason behind the search warrant requirement. Postjudgment execution procedures and writs of execution issued under the procedures did not sufficiently limit the deputies' discretion in executing the writs to satisfy constitutional search and seizure provisions. Thus, entry into Dorwart's residence and seizure of his property without permission or a warrant, relying only on the authority of the writs, violated Dorwart's constitutional search and seizure rights. Dorwart v. Caraway, 1998 MT 191, 290 M 196, 966 P2d 1121, 55 St. Rep. 777 (1998), following Neb. v. Hinchey, 374 NW 2d 14 (Nebr. 1985).

Constitutionality of Warrantless Police Search of Private Land Up to and Including Threshold of Residence -- Concept of Curtilage Inapplicable: Hubbel sought to suppress evidence gathered by police from the common parking area, sidewalk, and porch of Hubbel's residence on grounds that the officers were not on the property legally when they first observed evidence, rendering the search and seizure unlawful. Rather than analyzing the facts in the context of curtilage, the Supreme Court applied St. v. Bullock, 272 M 361, 901 P2d 971, 54 St. Rep. 173 (1995), in deciding the extent to which Hubbel had a legitimate expectation of privacy on his private property. The police parked in a general parking area used by other visitors, and after observing blood evidence in the driveway, they walked along the sidewalk to the front porch and discovered bullet holes in the front door, as well as other evidence in plain view. The officers did not ignore any posted warnings, hop fences, open gates, or slip through bushes intended to screen the home from view. In fact, the officers did nothing other than what any casual visitor to the Hubbel home would do. Because the intrusion in this case was minimal, the entry onto Hubbel's property leading up to and including the threshold of the residence did not require a warrant. The concept of curtilage did not apply because there was no evidence that the area surrounding the home was put to any special use that would indicate that the surrounding area was intimately connected with the home itself or that Hubbel reasonably expected that the surrounding area should be treated the same as the home itself. St. v. Hubbel, 286 M 200, 951 P2d 971, 54 St. Rep. 1373 (1997).

Retroactive Consent to Warrantless Search Disallowed: Hubbel voluntarily gave retroactive consent to a search of her property 5 months after police searched and seized evidence inside the Hubbel home. However, the requirement of advance justification, by virtue of a warrant or a carefully carved exception, is fundamental and inherent to all search and seizure cases. Applying the rationale in Terry v. Ohio, 392 US 1, 20 L Ed 2d 889, 88 S Ct 1868 (1968), the Supreme Court noted that exigent circumstances for conducting a warrantless search consist of circumstances that involve factors that exist when it is not practicable to secure a warrant,
such as a mobile vehicle, the possible destruction of evidence, safety of police officers, or other emergency situations, and must be apparent at the inception of the search. Requiring prior consent is the only view that makes sense in light of the purposes behind the suppression rule, which serves to deter lawless police conduct by excluding illegally obtained evidence. Thus, retroactive consent may not be used to validate a search, and the evidence seized as a result of the unlawful search in this case was inadmissible. St. v. Hubbel, 286 M 200, 951 P2d 971, 54 St. Rep. 1373 (1997).

State Use of Drug-Detecting Canine to Inspect Luggage Lawful -- No Unconstitutional "Search" or "Seizure": When a Tucson airport police officer noticed the defendant acting nervously prior to checking in for his flight to Billings, the officer called ahead and informed the Billings police department of his suspicion that the defendant was trafficking narcotics. A Billings police officer, accompanied by a drug-detecting canine, met the flight when it landed in Billings. Before the luggage was loaded onto the airport carousel, the canine was directed to sniff the luggage from the flight, upon which the canine's reaction indicated that the suitcase containing the description given by the Tucson police officer contained drugs. After picking up the suitcase off the carousel, the defendant was approached by a Billings police officer, who advised him of this rights and escorted him to the airport office. After the defendant refused to consent to a search, the officer obtained a search warrant and found that the suitcase contained 18 pounds of marijuana. The defendant, charged with possession of dangerous drugs, filed a motion to suppress the evidence, alleging that the state's use of a drug-detecting canine violated his right of privacy. The District Court denied the motion, concluding that the use of a drug-detecting canine did not constitute a search. On appeal, the Supreme Court affirmed, concluding that the use of a drug-detecting canine did not constitute a search. On appeal, the Supreme Court ruled that a person may have an expectation of privacy in an area of land beyond the curtilage that society recognizes as reasonable and where the expectation of privacy is evidenced by fencing, "no trespassing" signs, or some other means that unmistakably indicates that entry by law enforcement officers requires permission or a warrant. The court refused to apply the requirement to observations of private land from public property, but specifically overruled inconsistencies in its prior decisions in Charvat, Dess, Bennett, and Sorensen, which were decided prior to Oliver under the old two-part test in Katz v. U.S., 389 US 347 (1967), St. v. Bullock, 272 M 361, 901 P2d 61, 52 St. Rep. 717 (1995), followed in St. v. Romain, 1999 MT 161, 295 M 152, 983 P2d 322, 56 St. Rep. 638 (1999).

Constitutionality of Routine, Administrative Inventory Search -- Compelling State Interest: Under Montana's Constitution, the right of individual privacy is a fundamental right, but the guarantee of individual privacy is not absolute. That right may not be infringed without a showing of a compelling state interest, which must be closely tailored to effectuate only that compelling interest. With regard to a routine, administrative inventory search of personal property or in the possession of an arrestee at the station following a lawful arrest, the compelling state
interest is the protection of the arrestee, the police, other inmates and persons, and property in and around the station from harm and the potential for harm posed by weapons, dangerous instrumentalities, or hazardous substances that might be concealed or in the possession of the arrestee. In these instances, the "less intrusive means rule" discussed in St. v. Sawyer, 174 M 512, 571 P2d 1131 (1977), and St. v. Sierra, 214 M 472, 692 P2d 1273 (1985), is not mandated because it is impractical and unreasonable to expect police to make decisions on a daily basis about which containers to search and what, if any, would be the least intrusive means to inventory an arrestee's personal property on or in his possession. Further, the state has an interest in protecting an arrestee's property by accounting for money and articles to protect police against false claims for items taken while the arrestee is in custody, and an inventory search is a reasonable way to ensure protection of the arrestee's property during detention. Sawyer continues to be law regarding routine automobile searches when a defendant has been arrested and the vehicle impounded and when there are no exigent circumstances or other recognized exceptions from warrant requirements that justify a warrantless search. However, police may conduct a routine, administrative inventory search of an arrestee and of closed containers in the arrestee's possession at the time of arrest if the search is conducted pursuant to standardized policy or procedures adopted by police and routinely used in the booking process. St. v. Pastos, 269 M 43, 887 P2d 199, 51 St. Rep. 1441 (1994), following Ill. v. Lafayette, 462 US 640, 77 L Ed 2d 65, 103 S Ct 2605 (1983), and Colo. v. Bertine, 479 US 367, 93 L Ed 2d 739, 107 S Ct 738 (1987), distinguishing St. v. Sawyer, 174 M 512, 571 P2d 1131 (1977), and overruling St. v. Sierra, 214 M 472, 692 P2d 1273 (1985), to the extent of any inconsistencies with this decision.

Frisk and Search Incidental to Termination of Employment: An employment dispute, including threats by an employee against company management, led to a termination meeting. Because of the nature of the dispute, one of the managers requested the presence of a Sheriff at the meeting "to keep the peace". The Sheriff asked that the request and reasons for asking assistance be made in writing. The manager provided a written request, giving details of the threats. The Sheriff and two deputies were present and frisked the employee upon his arrival. The frisk and search lasted less than 2 minutes. On appeal, the employee contended that the company requested the Sheriff's presence at the meeting and that the ensuing frisk was an invasion of the employee's right of privacy, citing Johnson v. Supersave Mkt., Inc., 211 M 465, 686 P2d 209 (1984), for the premise that a person's right to liberty is legally protected from invasion and that emotional distress proximately caused thereby constitutes recoverable damages for invasion of privacy. The District Court properly held that the officer's search was not a substantial invasion of a legally protected interest, that the employee had provided no authority to support an invasion of privacy tort theory, and that the search was part of and could not be separated from the termination. There was no evidence that the employer participated in the decision to frisk and search, and an agency relationship was not established. Koepplin v. Zortman Min., Inc., 267 M 53, 881 P2d 1306, 51 St. Rep. 880 (1994).

Open Fields Doctrine Applied to Wooded Land: A criminal defendant argued that a warrantless search of his property was an invasion of privacy. The Supreme Court ruled that the right of privacy in one's home does not extend to open fields within view of the public and that the fact that the property was heavily wooded created no legitimate expectation of privacy. St. v. Sorensen, 243 M 321, 792 P2d 363, 47 St. Rep. 873 (1990), distinguished and overruled in part in St. v. Bullock, 272 M 361, 901 P2d 61, 52 St. Rep. 717 (1995). Bullock was followed in St. v. Romain, 1999 MT 161, 295 M 152, 983 P2d 322, 56 St. Rep. 638 (1999).

Warrantless Search by Probation Officer Lawful if Based on Reasonable Suspicion of Probation Violation: Defendant's deferred sentence was revoked after a warrantless search initiated by her probation officer pursuant to the terms of her probation revealed that defendant possessed dangerous drugs in violation of the terms of her probation. Search by a probation officer of his probationer's car, premises, or other belongings is lawful if it is based on the probation officer's reasonable suspicion of a probation violation. St. v. Small, 235 M 309, 767 P2d 316, 46 St. Rep. 9 (1989), followed in St. v. New, 276 M 529, 917 P2d 919, 53 St. Rep. 510 (1996), and St. v. Olmsted, 1998 MT 301, 292 M 66, 968 P2d 1154, 55 St. Rep. 1235 (1998).

Warrantless Police Search of Probationers' Car and Residence Allowed -- Reasonable Grounds Standard -- Fogarty Overruled: A police officer's warrantless search of the probationers' car and residence based on the officer's observations and with permission of the probation officer, in compliance with probationary conditions, did not violate the

Taking of Blood Sample Without Consent but Pursuant to Search Warrant -- No Privacy Invasion: In the instance of a non-DUI offense, an involuntary blood test supported by a valid search warrant issued with sufficient probable cause serves to protect the state's interest in enforcing its criminal laws and is not a violation of a person's right to privacy. Collins v. St., 232 M 73, 755 P2d 1373, 45 St. Rep. 878 (1988).


When Duty of Law Enforcement Officer to Investigate Overrides Individual Right of Privacy: When a trained and experienced officer has a particularized suspicion that the occupant of a vehicle is or has been engaged in criminal activity or is a witness thereto, that officer has a duty to investigate, and a limited and reasonable investigatory stop and search is justified. St. v. Morris, 230 M 311, 749 P2d 1379, 45 St. Rep. 234 (1988); St. v. Gopher, 193 M 189, 631 P2d 293, 38 St. Rep. 1078 (1981).

Shining of Ultraviolet Light Not Considered Search: Agents dusted money used in a drug deal with invisible detection powder that showed up only under an ultraviolet light. After defendant's arrest, his hands and wallet were inspected under ultraviolet light for traces of the dust and the positive results admitted into evidence. The Supreme Court adopted the rationale in Commonwealth v. DeWitt, 314 A2d 27 (Pa. Super. 1973), holding that the shining of the ultraviolet light did not constitute a search so as to implicate privacy rights under either the U.S. or Montana Constitution. The court found persuasive the fact that defendant was validly arrested, that the wallet was properly seized, and that the light only afforded an opportunity to learn if defendant may have touched the drug money. St. v. Holzapfel, 230 M 105, 748 P2d 953, 45 St. Rep. 53 (1988).

Valid Search of Wallet After Arrest: The District Court properly allowed into evidence the results of a postarrest, nonconsensual, warrantless search of defendant's wallet. The Supreme Court adopted the reasoning in U.S. v. Passaro, 624 P2d 938 (9th Cir. 1980), that a wallet is an element of clothing "which is, for a reasonable time following a legal arrest, taken out of the realm of protection from police interest". The search also satisfied the privacy guaranties of the Montana Constitution because the arrest reduced the arrestee's expectation of privacy. St. v. Holzapfel, 230 M 105, 748 P2d 953, 45 St. Rep. 53 (1988).

Search of Person Distinguished From Search of Possessions -- Reduced Expectation of Privacy: The Supreme Court, citing U.S. v. Monclavo-Cruz, 662 P2d 1285 (9th Cir. 1981), distinguished between searches of person and searches of possessions, holding that once a person is lawfully seized and arrested, the reasonable expectation of privacy is diminished as to a routine search of open personal property seized prior to incarceration since the state has a compelling interest in protecting prisoners from potential danger. Helena v. Lamping, 221 M 370, 719 P2d 1245, 43 St. Rep. 901 (1986), followed in St. v. Lamere, 226 M 323, 735 P2d 511, 44 St. Rep. 690 (1987). See also Colo. v. Bertine, 479 US 367, 93 L Ed 2d 739, 107 S Ct 738 (1987).

Warrantless Search -- Third-Party Right of Privacy: Police officers may not constitutionally enter the home of a third person in search of an escaped felon for whom they have a valid arrest
warrant unless exigent circumstances exist and probable cause leads them to believe the suspect will be found on the premises. The duty of police officers to search for and arrest those who commit crimes must be balanced with the right of innocent citizens to be secure in the privacy of their homes against unreasonable police invasion. 


Warrantless Search of Dwelling -- Defendant's Expectation of Privacy: The defendant escaped from prison and hid in his girlfriend's nearby home. Police officers, who had a valid arrest warrant for the defendant, discovered him when they conducted a warrantless search of the dwelling. On appeal, the Supreme Court ruled that the defendant had a legitimate expectation of privacy in his girlfriend's home and has standing to challenge the constitutionality of the search based on an arrest warrant rather than a search warrant. Admission of the evidence obtained from the search was not harmless error even though the defendant had testified to the circumstances surrounding his escape. St. v. Kao, 215 M 286, 698 P2d 403, 42 St. Rep. 363 (1985).

Privacy Right More Expansive Than Federal Provision: Defendant was arrested on suspicion of being an illegal alien even though he was legally in the United States. Defendant spoke no English, and an interpreter was not used to advise him of his rights. During booking, defendant was ordered to empty his pockets, and a small amount of what was later determined to be marijuana was found. Immediately the arresting officers opened defendant's suitcase and found 7 pounds of marijuana. At trial, defendant moved to suppress the marijuana seized from the suitcase. The trial court suppressed the evidence, and the State appealed. The Supreme Court held that under St. v. Sawyer, 174 M 512, 571 P2d 1131 (1977), an inventory search is a substantial infringement upon individual privacy and is subject to Art. II, sec. 10 and 11, Mont. Const. Montana's constitutional right of privacy does not make obtaining a search warrant any more difficult, but it does require that in many inventory searches, the least intrusive means possible must be used. The Montana Constitution's privacy right is broader than that under the guaranty against unreasonable search and seizure contained in the fourth amendment to the U.S. Constitution. Because less intrusive means were available for handling the suitcase, its contents were properly suppressed. St. v. Sierra, 214 M 472, 692 P2d 1273, 42 St. Rep. 106 (1985), overruled in St. v. Pastos, 269 M 43, 887 P2d 199, 51 St. Rep. 1441 (1994), but Sawyer continues to be law regarding routine automobile searches.

Apprehension of Felony Suspects -- Compelling State Interest: Defendant issued 13 bad checks totaling $231.76 between July 17, 1981, and October 30, 1981. On November 23, 1981, a Justice of the Peace issued an arrest warrant on the charge of issuing a bad check. There were no previous efforts to secure defendant's presence to answer the charge or post bond. On December 4, 1981, a Sheriff arrested defendant at his home. During booking, a full search of defendant was conducted and a gram of hashish was discovered. Defendant pleaded guilty to the bad check charge. The District Court granted his motion to suppress the contraband as an invasion of privacy under St. v. Carlson, 198 M 113, 644 P2d 498 (1982). The State appealed, and the Supreme Court vacated and remanded, stating that Carlson was clearly limited to traffic-related misdemeanors. The court held that full custodial arrests supported by a warrant for felonies are proper, and that the apprehension of felony suspects is a compelling state interest which justifies a full custodial arrest pursuant to warrant. The right of privacy must yield to a compelling state interest. St. v. Wood, 205 M 141, 666 P2d 753, 40 St. Rep. 1173 (1983).

Marijuana in Unfenced Garden -- Observation From Road by Police With Spotting Scope: When the State does not violate an individual's legitimate expectation of privacy, an unreasonable search has not taken place. Where no reasonable expectation of privacy exists, there is neither a search nor a seizure under the fourth amendment to the United States Constitution or Art. II, sec. 11, Mont. Const. There was no search when police stood on a county road and used a spotting scope to look for marijuana in a garden surrounded by open fields, and the marijuana obtained pursuant to a warrant to search garden was properly used as direct evidence in a prosecution for criminal possession of dangerous drugs. St. v. Bennett, 205 M 117, 666 P2d 747, 40 St. Rep. 1133 (1983), distinguished and overruled in part in St. v. Bullock, 272 M 361, 901 P2d 61, 52 St. Rep. 717 (1995). Bullock was followed in St. v. Romain, 1999 MT 161, 295 M 152, 983 P2d 322, 56 St. Rep. 638 (1999).

No Necessity for Arrest -- Subtle Coercion for Consent to Enter Home -- Subsequent Search Invalid: Defendant was involved in a minor traffic accident that was not his fault. He failed to produce his driver's license. The investigating officer later learned that the license was revoked. The officer made out
"Notice to Appear and Complaint" forms for operating a vehicle while driver's license was revoked and obstructing an officer, both misdemeanors. The officer gave the citations to the City Clerk for mailing to the defendant, but this was never done. A week later, the officer, thinking the citations had been mailed, requested and received an arrest warrant. Two officers went to defendant's house, awakened him, and informed him he was under arrest. Defendant requested he be allowed to get dressed. The officers told defendant they would have to accompany him and observed marijuana and bongs. They obtained a search warrant, returned and searched the house, and found small quantities of drugs and a stolen pistol. Defendant moved to suppress the evidence as obtained through an illegal search. The State contended that full custodial arrest was reasonable, was not connected to any pretextual arrangement that the police suspected defendant as a drug user, and that the search warrant based on the "plain view" observation of the officers in the home was valid. The District Court declined to determine whether the arrest was a pretext but decided there was no necessity for a full custodial arrest and suppressed the evidence. The court held that under the totality of the circumstances, the defendant had not consented to the officers' entry. The validity of the officers' entry into the home is the fulcrum upon which the case turns. The State justified the entry on the claim of defendant's consent. The Supreme Court found that the subjective state of defendant, "half asleep" and in his underwear, and the unqualified statement of the officers that if defendant were to get dressed they would have to come into his house, without any other explanation of his rights, constituted subtle coercion, and the search was unconstitutional. The court found no prior justification or exigency for the entry by the officers. Their entry under the facts of the case was unreasonable, and it is that factor which converted their observation in the house into a warrantless search, which is always presumed unreasonable. This was especially true in light of the requirement of the State to establish a compelling interest in order to overcome defendant's reasonable expectation of privacy in his home. St. v. Carlson, 198 M 113, 644 P2d 498, 39 St. Rep. 802 (1982).

**Prisoner on Furlough -- Lesser Right of Privacy Under Federal Constitution:** Plaintiff was released from prison on an educational furlough to attend the University of Montana (now University of Montana-Missoula). A deputy received a tip that plaintiff had drugs in his dorm room. The deputy called plaintiff's parole officer who determined that plaintiff had not signed a consent to be searched when furloughed. No search warrant was procured, but the search was conducted and drugs were seized. The evidence was suppressed and plaintiff's furlough reinstated. Plaintiff then brought this action seeking damages for violation of his civil rights. The federal courts have distinguished between a private citizen and a convict who is paroled prior to the expiration of his term, stating that a parolee does not have the expectations of privacy (see Art. II, sec. 10, Mont. Const.) enjoyed by other citizens. One of these restrictions is that the parolee and his home are subject to search by the parole officer when he reasonably believes that such search is necessary in the performance of his duties. Montana law may differ (see St. v. Fogarty, 187 M 393, 610 P2d 140 (1980)), but this case charged violation of the United States Constitution, and under it the search was not constitutionally infirm. Quigg v. France, 502 F. Supp. 516 (D.C. Mont. 1980).

**Unlimited Search and Polygraph Provisions on Probation Unconstitutional:** As conditions for imposition of a suspended sentence, defendant was required to submit to an unlimited search provision by any lawful authorities and to submit to a polygraph examination upon the request of any law enforcement officer. The Supreme Court when reviewing the revocation of defendant's suspended sentence held that the unlimited polygraph examination condition was overly broad and thus an invalid condition of probation and that the unlimited warrantless search provision is an unconstitutional condition of probation. The Supreme Court said that a sentencing court cannot inject prosecuting attorneys or law enforcement officials into the probation process by granting them direct rights to search the probationer, his home, or vehicle. A type of probable cause or some identifiable reason is required before a search clause may be exercised to search the probationer or his vehicle. The legal interests of innocent third persons living with a probationer are to be protected by requiring a search warrant before searching the probationer's home. Polygraph examinations as a condition of probation can be effectively contained within constitutional parameters by confining the right to demand a polygraph examination to the probation officer. St. v. Fogarty, 187 M 393, 610 P2d 140 (1980), overruled in St. v. Burke, 235 M 165, 766 P2d 254, 45 St. Rep. 2278 (1988).

**Odor Insufficient Probable Cause for Search Warrant:** The odor of burning marijuana does not by itself establish probable cause to issue a search warrant nor is it sufficient to justify the invasion of
the privacy of one's home. St. v. Olson, 181 M 151, 589 P2d 663 (1979).

Inventory Search -- Not Justified: Contraband found under a seat during inventory of an automobile held in police custody was not in plain view, thus it was seized in violation of individual privacy and freedom from unreasonable searches. The inventory search was not justified by protection of the contents for the owner's benefit or protection of the police from claims for lost property beyond articles in plain view from outside the vehicle. St. v. Sawyer, 174 M 512, 571 P2d 1161 (1977), followed in St. v. Sierra, 214 M 472, 692 P2d 1273, 42 St. Rep. 106 (1985). Sawyer continues to be law regarding routine automobile searches, but Sierra overruled in St. v. Pastos, 269 M 43, 887 P2d 199, 51 St. Rep. 1441 (1994).

ELECTRONIC SURVEILLANCE

Warrantless Use of Thermal Imaging as Unconstitutional Search: The use of thermal imaging in a criminal investigation to detect heat and infrared radiation from outside a structure, such as that generated by an indoor marijuana growing operation, constitutes a search under Art. II, sec. 11, Mont. Const. The privacy interests of this section are also implicated by the use of thermal imaging technology. In the present case, defendants housed activities that they wished to keep private in an enclosed structure on posted, fenced property behind locked gates. As such, defendants had a subjective expectation of privacy in the heat signatures of activities, intimate or otherwise, pursued within the confines of their private homes and enclosed structures, which they did not knowingly expose to the public. Montana's Constitution affords citizens broader protection from warrantless governmental intrusion in search and seizure cases than does the United States Constitution. This heightened expectation of privacy is one that society is willing to recognize as objectively reasonable. Therefore, use of thermal imaging technology by the government in the absence of a search warrant requires the demonstration of a compelling state interest closely tailored to effectuate only that compelling interest, not simply enforcement of the criminal statutes. In the absence of these factors, use of the technology violated defendants' right to privacy. St. v. Siegal, 281 M 250, 934 P2d 176, 54 St. Rep. 158 (1997), following St. v. Solis, 214 M 310, 693 P2d 518 (1984), St. v. Young, 867 P2d 593 (Wash. 1994), U.S. v. Ishmael, 48 F3d 850 (5th Cir. 1995), U.S. v. Cusumano, 67 F3d 1497 (10th Cir. 1995), and St. v. Bullock, 272 M 361, 901 P2d 61 (1995).

Admissibility of Recording of Warrantless Face-to-Face Conversation by Police Use of Body Wire Transmitting Device: Warrantless consensual electronic monitoring of face-to-face conversations by the use of a body wire transmitting device, when performed by law enforcement officers while pursuing their official duties, does not violate the constitutional right to be free of unreasonable search and seizure or the right of privacy. Consent must be clearly obtained from at least one party to the conversation and must be freely made and without compulsion. As in telephone conversations, the consenting party may be an informant or police officer. Evidence obtained from such monitoring is admissible in a subsequent criminal trial. St. v. Brown, 232 M 1, 755 P2d 1364, 45 St. Rep. 818 (1988), overruling St. v. Brackman, 178 M 105, 582 P2d 1216 (1978). See also St. v. Staat, 251 M 1, 822 P2d 643, 48 St. Rep. 1041 (1991).

Interpretation of Largely Inaudible Tape Recording by Police -- No Prejudice: It was not prejudicial to allow introduction of mostly inaudible tape recordings made with the consent and participation of an informant nor to allow a police officer who was present when the recordings were made to act as an oral transcriber to interpret what was said and what occurred while the tapes were being made. St. v. Morse, 229 M 222, 746 P2d 108, 44 St. Rep. 1919 (1987).

Warrantless Covert Videotaping of Defendant's Conversation With Undercover Agent: An undercover agent videotaped the conversation without defendant's knowledge or consent. Defendant successfully moved to suppress the tape as violative of his right to privacy under the Montana Constitution. The Supreme Court ruled that the trial court properly found defendant's right to privacy was violated because he had an actual expectation of privacy, the expectation was reasonable, and the State had not exhibited a compelling interest justifying its invasion of defendant's privacy. The court held that in face-to-face encounters in a private setting, there is a reasonable expectation that monitoring is not taking place. The right to privacy is the cornerstone of protections against unreasonable searches and seizures. St. v. Solis, 214 M 310, 693 P2d 518, 41 St. Rep. 2493 (1984).

Consent to Monitor Telephone Conversation: In holding that the recording of a telephone conversation between an informant and defendant
was not a violation of this section, the Supreme Court, following St. v. Hanley, 186 M 410, 608 P2d 104 (1980), held that a court order is not necessary to monitor a telephone conversation if one of the parties to the telephone conversation consents. The Supreme Court distinguished St. v. Brackman, 178 M 105, 582 P2d 1216 (1978), because in Brackman it held there was an invasion of privacy because persons engaged in conversation in an open parking lot have a reasonable expectation of privacy whereas with a telephone conversation such an expectation does not exist. St. v. Cole, 189 M 492, 616 P2d 1090, 37 St. Rep. 1661 (1980), followed in St. v. Canon, 212 M 157, 687 P2d 705, 41 St. Rep. 1659 (1984).

### Standard for Issuance of Order Allowing Electronic Surveillance -- Compelling State Interest:
Where police officers obtained an order for electronic surveillance of the defendant, an affidavit supporting the request for the order which recited facts showing the defendant to be in possession of dangerous drugs satisfied the standard for issuance of electronic surveillance orders announced in St. v. Brackman, 178 M 105, 582 P2d 1216 (1978), in which the Supreme Court held that the state must show a compelling state interest to obtain this kind of order. The enforcement of criminal laws is essential to the preservation of an orderly society and is a compelling state interest sufficient to support the issuance of the order. St. v. Cole, 189 M 492, 616 P2d 1090, 37 St. Rep. 1661 (1980), followed in St. v. Canon, 212 M 157, 687 P2d 705, 41 St. Rep. 1659 (1984).

### Grounds for Granting Motion for Directed Verdict -- Invasion of Privacy Action:
Where the respondent telephone company conducted a recording on a party line for a period of 6 days for the alleged purpose of protecting the quality of its services, the District Court erred in granting a motion for a directed verdict filed by respondent at the close of appellant's case. Considering the nature and extent of the recording and comparing it to recordings in other cases in which the recordings are allowed only in limited circumstances, namely, where telephone fraud is an issue, reasonable men could draw different conclusions as to whether the recording could be classified in such a way as to be allowable under the federal statute; thus the directed verdict should not have been granted. Sistok v. NW. Tel. Systems, 189 M 82, 615 P2d 176, 37 St. Rep. 1247 (1980), citing Lawlor v. Flathead County, 177 M 508, 582 P2d 751 (1978).

### Requirements for Electronic Surveillance:
Under Title III of the federal Omnibus Crime Control and Safe Streets Act, states are required to have a specific statutory scheme for electronic surveillance before public officials can lawfully monitor oral and wire communications in the state. If a state chooses to allow electronic surveillance by adopting a statutory scheme, the scheme must be at least as or more restrictive than the regulations of Title III. Montana statutes 45-8-213, defining the offense of violating privacy in communications, and 46-5-202 (renumbered 46-5-221), setting forth the grounds for issuance of a search warrant, fail to meet the minimum requirements of Title III or the standard enumerated by the U.S. Supreme Court in the Berger and Katz decisions. Among other things, Montana's statutes fail: (1) to require a showing of exigent circumstances to overcome the defect of not giving prior notice; (2) to state what items of information should be included in the application for a warrant; and (3) to outline the general procedures by which law enforcement officials obtain warrants for electronic surveillance. In St. v. Brackman the court held that in view of Montana's constitutional right of privacy, law enforcement officials must first obtain a warrant before intercepting any communication. This will no longer suffice, since the requirements of Title III are not met. Any evidence seized by electronic surveillance must be suppressed since Montana's statutory scheme for allowing such surveillance does not meet the federal requirements, St. v. Hanley, 185 M 459, 605 P2d 1087 (1979), opinion withdrawn on rehearing, St. v. Hanley, 186 M 410, 608 P2d 104 (1980), and followed in St. v. Lynch, 1998 MT 308, 292 M 144, 969 P2d 920, 55 St. Rep. 1278 (1998). Lynch was followed in St. v. Pizzichiello, 1999 MT 123, 294 M 436, 983 P2d 888, 56 St. Rep. 499 (1999).

### Unauthorized Recording of Telephone Call -- Third Person's Right to Privacy Invaded:
Recording of telephone conversations by police undercover officer of a call received from an acquaintance of defendant setting up a drug sale did not taint all evidence against defendant even though the recording was not authorized by court order. The undercover officer personally contacted police regarding the setting up of the drug buy which resulted in defendant's conviction. Furthermore, defendant cannot invoke a breach of right of privacy of his acquaintance; he must assert his own privacy rights. The recording was not introduced into evidence, but the undercover officer testified concerning it. St. v. Hanley, 186 M 410, 608 P2d 104 (1980), superseding on rehearing St. v. Hanley, 185 M 459, 605 P2d 1087 (1979).

### Police Monitoring:
Article II, sec. 10 and 11.
Mont. Const., protects the individual from any monitoring and recording by the state without a search warrant or prior showing of compelling state interest of conversations between the individual and police informants even though the informants consented to the monitoring and recording. Section 45-8-213 does not give consensual participant consented to the monitoring and recording. Section 45-8-213 does not give consensual participant monitoring the status of a compelling state interest. 


PUBLIC AND PRIVATE RECORDS

Revealing Limited Medical Information During Police Interview Not Considered Waiver of Constitutional Right to Confidentiality in Medical Records -- Voluntary Medical Information Outside Scope of Fruit of Poisonous Tree Doctrine -- Adequate Probable Cause for Investigative Subpoena of Medical Records: Bilant was involved in a three-car accident and was subsequently arrested for DUI and a seat belt violation. During an interview following the arrest, Bilant revealed to an officer that he had taken pain medication on the day of the accident. The officer called Bilant's health care provider for confirmation, and the provider confirmed that Bilant had a prescription for a drug similar to the pain medication that he mentioned. The officer then procured an investigative subpoena regarding documentation on all prescriptions issued to Bilant, including any advisory warnings, and the provider sent Bilant's entire medical file. Bilant contended that the state violated both his constitutional right to privacy and the statutory protections of 50-16-535. The state maintained that Bilant waived his claim of confidentiality in his medical information when he voluntarily revealed his use of pain medication to the officer. The Supreme Court agreed with Bilant. Medical records are quintessentially private and deserve the utmost constitutional protection. None of the statutory prerequisites for disclosure of the medical records were met. In deciding to reveal limited medical information in a police interview, Bilant did not forfeit his constitutional right to subsequently claim confidentiality in his medical records. The officer conducted an illegal search in seeking the constitutionally protected private medical information without probable cause and the benefit of an investigative subpoena under 46-4-301, and the information gleaned from the telephone call should have been suppressed. Bilant then contended that the use of the illegally obtained information formed an improper basis for the investigative subpoena and that the results of the subpoena should also have been suppressed pursuant to the fruit of the poisonous tree doctrine, which forbids the use of evidence that comes to light as the result of an initially illegal act. However, on this point, the Supreme Court disagreed with Bilant. One exception to the doctrine is that the derivative evidence is admissible if it is obtained from an independent source. Here, Bilant himself provided the source by giving voluntary medical information from other than the illegal telephone inquiry. The Supreme Court recognized that an investigative subpoena seeking constitutionally protected medical information requires greater justification for state access than the administration of justice rationale used to obtain public information under 46-4-301, so in reviewing the probable cause basis for constitutionally protected material, the court excised the illegal evidence from the application and reviewed the remaining information de novo to determine whether probable cause existed for issuing the subpoena. In this case, even when the information subject to suppression was excised, the remaining evidence established probable cause that a DUI was committed and underscored a compelling state interest in medical records related to prescription medicines in order to confirm Bilant's initial admission to the officer. Thus, the subpoena was issued in accordance with the statutory requirements for constitutionally protected medical records, and Bilant's conviction was affirmed. St. v. Bilant, 2001 MT 249, 307 M 113, 36 P3d 883 (2001). See also St. v. New, 276 M 529, 917 P2d 919 (1996), and St. v. Nelson, 283 M 231, 941 P2d 441 (1997).

Settlement Agreement Involving Minor Child Open for Public Inspection -- No Right of Privacy Recognized -- Demands of Privacy Do Not Exceed Merits of Public Disclosure: Pengra and the state agreed to a settlement of Pengra's suit against the state on behalf of his daughter and himself involving the death of his wife. Pengra requested that the settlement document be sealed and thereby made unavailable for public inspection. In a challenge to the sealing of the settlement agreement, the Supreme Court held that: (1) minors have no greater right of privacy than adults in settlement agreements involving claims against the state; (2) Pengra had no subjective expectation of privacy in the settlement agreement; (3) by the Legislature's enactment of 2-9-303, society is not willing to recognize any privacy expectation of Pengra regarding the settlement agreement; (4) compelling policy reasons support the disclosure of the settlement; and (5) any right of privacy by Pengra in the settlement agreement did not outweigh the merits of public disclosure of that.

Unconstitutionality of Department of Revenue Rule Concerning Confidentiality of Coal Severance Tax Information: Plaintiffs sought information regarding coal severance tax payments that had been routinely supplied to the Department of Revenue by coal mine operators prior to adoption of ARM 42.2.701, which declared certain information, such as tax returns that taxpayers are required to submit to the Department, to be confidential. Plaintiffs challenged the rule on grounds that it violated constitutional and statutory rights to public information. The Department asserted that the rule was adopted to protect taxpayers' constitutional right to privacy and to inform the public of the Department's procedures regarding the confidentiality of tax information. The District Court found that the rule was adopted after balancing the public's right to know with the coal producers' right to privacy and that the producers had a reasonable and ongoing expectation of privacy that outweighed the public's right to know. On appeal, the Supreme Court disagreed, finding ARM 42.2.701 unconstitutional on its face. The rule presumes a wholesale constitutionally protected right to privacy for all taxpayers that prevails over public disclosure without balancing the taxpayers' right to privacy with the public's right to know. Prior to adoption of the rule, coal producers did not have an actual or subjective expectation of privacy in revenue information submitted to the Department. After the rule was adopted, the producers could assert a subjective expectation of privacy. However, based on a facially unconstitutional rule, the expectation was not one society would be willing to recognize as reasonable, especially when the information had been routinely available for nearly 20 years before ARM 42.2.701 was adopted. Neither prong of the two-part privacy test in Great Falls Tribune Co., Inc. v. Day, 1998 MT 133, 289 M 155, 959 P2d 508 (1998), having been met, a constitutionally protected privacy interest in the information was ruled out. Assoc. Press, Inc. v. Dept. of Revenue, 2000 MT 160, 300 M 233, 4 P3d 5, 57 St. Rep. 657 (2000).

In Camera Review of Criminal Justice Information Required to Balance Privacy Interests Against Right to Know: As part of its complaint, the Lincoln County Board of County Commissioners requested an evidentiary hearing, seeking the release of criminal justice system information related to an investigation of the Commission by the state. The state Criminal Investigation Bureau contended that the investigative file contained confidential information, the release of which would compromise both the investigation and the privacy interests of informants and witnesses. The District Court canceled the hearing, denied the request for dissemination of the investigative materials, and dismissed the complaint with prejudice. On appeal, the Supreme Court reversed, noting that an analysis of potentially competing privacy interests of the parties was necessary in order to balance those interests against the Commission's right to know. On remand, the District Court was instructed to conduct an in camera inspection of the investigative file in order to determine what material could be released to the Commission while maintaining the privacy of witnesses and informants and was instructed to limit the release of any investigative information by protective order. Lincoln County Comm'n v. Nixon, 1998 MT 298, 292 M 42, 968 P2d 1141, 55 St. Rep. 1222 (1998).

Full and Accurate Disclosure of Adoption Information Required: The Jacksons' adoptive son required extensive medical and psychological therapy. The Jacksons sued the state, contending that the state had a legal duty to inform them of the boy's condition and of his parents' medical backgrounds and that failure to do so constituted negligent misrepresentation, negligent nondisclosure, negligence based on lack of informed consent, and negligent supervision. The state contended that the imposition of a common-law or statutory duty to disclose the background information would conflict with its duty to maintain confidentiality of the birth parents' medical records. The District Court dismissed the claims, concluding that the state owed the Jacksons no duty of care upon which the negligence claims could be premised. Citing the opinions of several courts of other states, the Supreme Court held that recognizing a cause of action for negligent misrepresentation in the adoption context would promote public policy and ensure that adoptive parents would assume parenting responsibilities in an informed manner. Anything less than the exercise of due care in the dissemination of information to prospective adoptive parents is unacceptable. Although a slight burden is imposed on the state in providing the information, that burden is justified in light of the compelling need for adoptive parents to receive all available information regarding a child who might soon be a permanent member of the family. Full disclosure of a child's medical and familial background is warranted not only to enable adoptive parents to obtain timely and appropriate
Right of Privacy Encompasses "Autonomy" and "Informational" Privacy -- Probable Cause Needed for Discovery of Medical Information: While treating the defendant for a broken jaw received during an automobile accident, the physician, concerned over the defendant's lack of pain, ordered a blood test to determine his alcohol concentration level. During a subsequent interview with the investigating officer, the physician referred to the victim's blood concentration level without divulging the actual numerical concentration level. Based on the physician's comments, the officer obtained the test results, using an investigative subpoena, and the defendant was subsequently charged with and convicted of driving under the influence of alcohol. The defendant appealed, alleging that release of the blood alcohol information violated his right to privacy. Although it affirmed the defendant's conviction, the Supreme Court ruled that absent a compelling state interest, medical records are protected by the right of privacy. The court adopted an interpretation of the state's privacy guarantee, outlined by California in Hill v. Nat'l Collegiate Athletic Ass'n, 865 P2d 633 (Calif. 1994). The court ruled that Montana's guarantee of privacy encompasses "autonomy privacy" as well as confidential "informational privacy". In this case, the state was able to establish the existence of a compelling state interest for the issuance of an investigative subpoena for discovery of medical records by showing that there was probable cause to believe that an offense had been committed and that the medical information relative to the offense was in the possession of a person to whom the subpoena was directed. St. v. Nelson, 283 M 231, 941 P2d 441, 54 St. Rep. 576 (1997), followed in St. v. Dolan, 283 M 245, 940 P2d 436, 54 St. Rep. 583 (1997), but ruling that information concerning a request that a hospital obtain a routine blood sample was insufficient to establish probable cause for issuance of an investigative subpoena, St. v. Ingraham, 1998 MT 156, 290 M 18, 966 P2d 103, 55 St. Rep. 611 (1998), and St. v. Bilant, 2001 MT 249, 307 M 113, 36 P3d 883 (2001).

No Reasonable Expectation of Privacy by Elected Official in Duty-Related Issues: A citizens' group organized to recall Mayor Whitlock sought public disclosure of a report that was ruled to be confidential by a closed meeting of the City Council. The report explored allegations of the mayor's misconduct in office and did not disclose information related to Whitlock's private activities, general performance evaluations, or proceedings in which his character, integrity, honesty, or personality were discussed. As an elected official, Whitlock's expectation of privacy regarding his public duties was unreasonable. The merits of disclosing the report were substantial and in the public interest of being informed of the actions and conduct of their official and of the expenditure of public funds. In ordering disclosure, the District Court properly found that the right of the public to know should be accorded greater weight than Whitlock's unreasonable claim of privacy. Citizens to Recall Mayor James Whitlock v. Whitlock, 255 M 517, 844 P2d 74, 49 St. Rep. 1113 (1992), distinguishing Mont. Human Rights Div. v. Billings, 199 M 434, 649 P2d 1283 (1982), Missoulian v. Bd. of Regents, 207 M 513, 675 P2d 962 (1984), and Flesh v. Mineral & Missoula Counties, 241 M 158, 786 P2d 4 (1990).

In Camera Inspection of Private Employment Records -- Court Discretion in Suppressing Discovery Proper: The state attempted to compel discovery of defendant's personnel files from the Helena Catholic Diocese. The state sought information regarding reports of similar misconduct, disciplinary actions, transfer records, and witness names to use in rebutting and cross-examining defendant's character witnesses. After initial refusal to surrender the records, the parties agreed to an in camera review of the records by the presiding judge. The judge ruled that the information was not discoverable because it contained personal and private information. The in camera review and the subsequent prohibition on discovery of material that was not probative were held to be within the discretionary power of the judge in controlling discovery. Absent an abuse of that discretion, denial of access to the records was affirmed. St. v. Burns, 253 M 37, 830 P2d 1318, 49 St. Rep. 353 (1992).

Defendant's Discovery Needs Balanced by Plaintiff's Right to Privacy: The defendant in a personal injury case sought access to the files of Mapes's psychologist. Mapes resisted the motion on the basis that it violated his right to privacy. The Supreme Court held that granting the supervisory writ was necessary because the defendant's discovery rights and the plaintiff's statutory privacy rights were...

Release of Police Records to Insurance Company: When an insurer sought access to police files pertaining to the police department's investigation of the death of an insured for use during the insurer's investigation of policy coverage, the police department objected to release of its records. The insurer then filed an application with the District Court, seeking production of the records. The court denied the application, holding that the insurer was not authorized by law to receive the documents and therefore was not entitled to their production under the Montana Criminal Justice Information Act of 1979. The trial court interpreted 44-5-303 to mean that in order to be "authorized by law", one must be specifically authorized by statute to receive criminal justice information. The Supreme Court held that this interpretation does not take into consideration basic tenets of our constitutional system of government and statutory construction. Under its commonly understood meaning, the word "law" includes constitutional as well as statutory law. Accordingly, one is authorized to receive criminal justice information by the "right to know" provision of the constitution. The only limitation on the right to receive this information is the constitutional right of privacy. Any interpretation of 44-5-303 that requires specific legislative authorization to review criminal justice information would render the statute unconstitutional. In this instance, the District Court shall conduct an in camera inspection of the documents at issue to determine what material could properly be released, balancing the competing interests of the right to know and the right of privacy. Allstate Ins. Co. v. Billings, 239 M 321, 780 P2d 186, 46 St. Rep. 1716 (1989), followed in Bozeman Daily Chronicle v. Bozeman Police Dept., 260 M 218, 859 P2d 435, 50 St. Rep. 1014 (1993).

Closure of Probation Revocation Hearing -- Interruption a Contempt -- Prior Notice of Closure Not Required: The public and the press have the right, with limited exception, to attend and observe probation revocation hearings. In a proper case, a District Court may close such a hearing. When a hearing is properly closed, no member of the public or representative of the press may interrupt the due course of the hearing in a manner that might defeat the reason for closure. Such an interruption constitutes a contempt of court. A District Court may proceed on an ad hoc basis, without giving prior notice, to make a closure decision in accordance with the facts and circumstances facing it at the time. State ex rel. Great Falls Tribune Co., Inc. v. District Court, 238 M 310, 777 P2d 345, 46 St. Rep. 1292 (1989).

Disciplined Police Officers' Right to Privacy Outweighed by Public's Right to Know: Several police officers were disciplined as a result of their actions during the chase and apprehension of a suspect. Law enforcement officials refused to release the names of the officers to the newspaper on the basis that to do so would violate the officers' privacy rights. The Supreme Court upheld the lower court's order to disclose the names on the basis that officers who have been disciplined have only a minimal right of privacy that is easily outweighed by the peoples' right to know. Great Falls Tribune Co., Inc. v. Sheriff, 238 M 103, 775 P2d 1267, 46 St. Rep. 1123 (1989), followed in Lence v. Hagadone Inv., 258 M 433, 853 P2d 1230, 50 St. Rep. 601 (1993).

Request of Law Enforcement Records for School Project -- Information Beyond Public Reach: The District Court properly refused the request of a student who sought Sheriff's department information for a school project. Information requested included: (1) records of the daily log of phone calls; (2) case files of criminal investigations; (3) preemployment investigation reports; and (4) lists of arrested persons. Persons involved had an actual expectation of privacy, and the interests of society were furthered by recognition of the privacy interest as reasonable. The student had the right to view and record statistical information pursuant to 44-5-103, but the requested information was protected by the Montana Constitution and the Montana Criminal Justice Information Act of 1979 and was beyond the reach of the public sector. Engrav v. Cragun, 236 M 260, 769 P2d 1224, 46 St. Rep. 344 (1989).

Limited Disclosure of Realty Transfer Certificate Information: The language of this section protects the confidentiality of a realty transfer certificate (RTC) when the demand for individual privacy exceeds the merits of public disclosure. However, when limited disclosure of relevant RTC information is crucial to a fair and informed decision by a tax appeal board or court, such disclosure outweighs individual privacy. Therefore, in contested tax
proceedings, relevant information from an RTC must be disclosed to the taxpayer party, tax boards, and reviewing courts. During pendency of the proceedings, RTC information will not be available to the public, and after the proceedings any portion of the record containing disclosed RTC information must be sealed. Under this holding, a taxpayer may apply to the District Court for a subpoena to compel the Department of Revenue to release relevant RTC information. The subpoena must identify the specific information requested with as much precision as possible. Issuance and scope of the subpoena lies within the discretion of the District Court. O'Neill v. Dept. of Revenue, 227 M 226, 739 P2d 456, 44 St. Rep. 1037 (1987).

Investigation of Human Rights Violations -- Personnel Files: The Human Rights Commission (HRC) requested access to personnel files in connection with its investigation of a discrimination complaint. The court found that information sought by the HRC is protected by the right of privacy. The court also found that a sufficient showing of compelling state interest was made under Art. II, sec. 4, Mont. Const., and Title 49, ch. 2, allowing the HRC access to the information. To protect the privacy of the individuals whose files are disclosed, the court directed that the HRC may not disclose the information unless it is altered so as to provide for the anonymity of the persons involved. If the information must be released in such a way as to disclose the identity of the persons involved, HRC must, prior to the release, obtain an order from the District Court authorizing the release. Mont. Human Rights Div. v. Billings, 199 M 434, 649 P2d 1283, 39 St. Rep. 1504 (1982), followed in Flesh v. Bd. of Trustees, 241 M 158, 786 P2d 4, 47 St. Rep. 161 (1990).

No Expectation of Privacy in Telephone Records -- State Action Theory Rejected: Where defendant examined telephone company records of telephone calls made by plaintiff and plaintiff alleged violation of right to privacy under Art. II, sec. 10, Mont. Const., the Supreme Court held that there is no reasonable expectation of privacy in telephone records justifying bringing them under constitutional protection. The Supreme Court, however, rejected the District Court’s reasoning for granting summary judgment to defendant, which was based on an interpretation of this section as requiring state action and as not protecting against violations by private persons. Hastetter v. Behan, 196 M 280, 639 P2d 510, 39 St. Rep. 100 (1982).


Trade Secrets -- When to Be Disclosed and to Whom -- Protectable Property: A telephone utility was required to disclose trade secrets to the Public Service Commission (PSC) to aid in a decision on its rate increase request. The utility was entitled to a protective order preventing access to the secrets by the general public, but the Montana Consumer Counsel and any citizen whose interest related to the ratemaking function of the PSC could have access to the information. Use or disclosure of the trade secrets except for purposes of the ratemaking proceeding was prohibited. Mtn. States Tel. & Tel. v. Dept. of Public Service Regulation, 194 M 277, 634 P2d 181, 38 St. Rep. 1479 (1981).

MISCELLANEOUS

Good Cause Required for Court-Ordered Medical Examination -- Scope of Medical Examination Rule: Pursuant to Rule 35, M.R.Civ.P. (Title 25, ch. 20), the District Court ordered plaintiff to undergo an extensive independent medical examination by an expert 750 miles away. The examination would have subjected plaintiff to burdensome, painful, invasive, elective, and potentially harmful procedures. After accepting supervisory control, the Supreme Court reversed. Rule 35 does not permit any proposed examination simply because a plaintiff puts the plaintiff's physical or mental condition at issue. A District Court must consider whether good cause for a proposed examination has been demonstrated because of the constitutional protections afforded to a person's right to privacy, safety, health, and happiness. Good cause for an examination may not constitute good cause for a specific examination requested by a defendant. Further, bringing a suit to recover for personal injury may place a plaintiff's physical or mental condition at issue, but it does not waive the inalienable right to the integrity of and personal control over the plaintiff's body. In determining whether there is good cause, the court should consider both the location and the nature of the examination. Requiring a party to travel any farther than necessary is an abuse of discretion, and
out-of-state examinations should be viewed with disfavor when an adequate examination can be conducted in Montana. Here, the District Court abused its discretion in ordering plaintiff to undergo a potentially invasive, painful, and burdensome examination at a distant location when the same test was available in Montana. Simms v. District Court, 2003 MT 89, 315 M 135, 68 P3d 678 (2003).

Noninvestigatory, Work-Related Entry Into Judge's Chamber Not Considered Search: Smartt, a Justice of the Peace, left his office computer on after work hours. A county employee and another judge entered Smartt's chambers to shut down the computer so that a network backup could be performed and discovered pornographic images displayed on the computer screen. They reentered the chambers to note websites from the computer history file and took digital photographs of the long-term history of internet activity on Smartt's computer. The information was turned over to the FBI, and Smartt's computer was confiscated and searched. Smartt contended that the evidence seized from his chambers was obtained through an unlawful search, violated the right to privacy, and should be suppressed. The Supreme Court disagreed. Under St. v. Boyer, 2002 MT 33, 308 M 276, 42 P3d 771 (2002), the Supreme Court considers three factors when determining whether there has been an unlawful government intrusion into one's privacy: (1) whether the person has an actual expectation of privacy; (2) whether society is willing to recognize that expectation as objectively reasonable; and (3) the nature of the state's intrusion. When no reasonable expectation of privacy exists, there is neither a search nor seizure. Although the Montana Constitution affords broader protection than the federal constitution in cases involving searches of and seizure from private property, a person may not expect the same degree of privacy in public that is afforded in the privacy of one's home. In this case, entry into the judge's chambers was for a legitimate, noninvestigatory, work-related purpose. Irrespective of whether Smartt had any expectation of privacy with regard to the computer images, the nature of the intrusion did not rise to the level of a search, and denial of the motion to suppress the evidence was proper. Harris v. Smartt, 2002 MT 239, 311 M 507, 57 P3d 58 (2002), distinguishing Gryczan v. St., 283 M 433, 942 P2d 112 (1997). See also St. v. Scheetz, 286 M 41, 950 P2d 722 (1997).

Action for Damages Allowed Against Local Peace Officers Violating Person's Self-Executing State Constitutional Rights to Privacy, Due Process, and Freedom From Unreasonable Searches and Seizures: Plaintiffs filed a civil action against the Sheriff and two deputies for damages for violation of plaintiffs' Montana constitutional rights to privacy, due process, and freedom from unreasonable searches and seizures. The court held that those three rights are self-executing. The court also held that plaintiffs were entitled to damages. The court based the right to recover damages on: (1) federal cases allowing damage suits for violation of rights under the U.S. Constitution; (2) Restatement (Second) of Torts 874A (1979), which follows the principle in those federal cases by stating that when a constitutional provision protects a class of persons and does not provide a remedy for a violation of the provision, the court may, if appropriate, allow an action under an existing tort or a new cause of action similar to an existing tort; (3) 1-1-109 providing that the common law of England is the rule of decision in Montana courts to the extent that it is not repugnant to or inconsistent with the U.S. or Montana Constitution or Montana statutes, and cases from other states using the English common law as a basis for granting a remedy for a state official's violation of a person's state constitutional rights; (4) 27-1-202 allowing recovery of damages by a person who suffers detriment from the unlawful act or omission of another; and (5) the Montana Constitution, Art. II, sec. 16, right to a remedy for every injury. The court stated that there is a great distinction between wrongs, such as assault, conversion, and trespass, by a private individual against another private individual and wrongs against a private individual by a person acting under authority of the state in violation of a person's constitutional rights and stated that common-law causes of action remedying the former are not adequate to remedy the latter. Dorwart v. Caraway, 2002 MT 240, 312 M 1, 58 P3d 128 (2002).

Writs of Execution Used to Enter, Search, and Seize -- Damages for Violation of Constitutional Rights -- Immunity of Peace Officers: Two brothers sued the Sheriff and two deputies for violating their Montana constitutional rights to privacy, due process, and freedom from unreasonable searches and seizures. Neither writs of execution issued to enforce default judgments against one brother nor the postjudgment statutes under which they were issued expressly directed or authorized local peace officers to enter the other brother's house and search for and seize property of the brother against whom the writs were issued and who lived in the house. Therefore, 2-9-103 did not give the peace officers immunity from suit on the basis that they acted "under the authority of law". However, to the extent that any claim for
Prohibition Against Abortion by Physician Assistant-Certified Unconstitutional Violation of Right of Privacy: After the decision in Mazurek v. Armstrong, 520 US 968, 138 L Ed 2d 162, 117 S Ct 1865 (1997), ibid., Dr. Armstrong and Cahill, a physician assistant-certified, filed this case in state District Court challenging the constitutionality of 37-20-103 and 50-20-109, which prohibited a physician assistant-certified from performing abortions. The District Court found that the prohibition affected a woman's right to obtain a legal first trimester abortion and that the state had advanced no compelling interest to justify prohibiting Cahill from performing abortions, as she had for 20 years, and granted plaintiffs' motion for a preliminary injunction. Noting that Montana adheres to one of the most stringent protections of its citizens' right of privacy in the United States, exceeding even the federal constitution, the Supreme Court affirmed, holding that legislation that infringes on the exercise of the right of privacy must be reviewed under a strict scrutiny analysis. Under this section, every individual is guaranteed the right to make medical judgments affecting that person's bodily integrity and health, in partnership with a chosen health care provider and free from government interference, except in very limited circumstances not at issue here. The court agreed that the statutory restrictions in question impacted a woman's right to procreative autonomy and her right to seek and obtain a specific lawful medical procedure from the health care provider of her choice, in this case a previability abortion from a physician assistant-certified, and were thus an unconstitutional violation of the right of privacy. Armstrong v. St., 1999 MT 261, 296 M 361, 989 P2d 364, 56 St. Rep. 1045 (1999), following Gryczan v. St., 283 M 433, 942 P2d 112, 54 St. Rep. 699 (1997). See also Intermt. Planned Parenthood v. St. (Cause No. BDV 97-477) (June 29, 1998) (First Judicial District Court ruling (not appealed to Montana Supreme Court) that the law banning partial-birth abortion procedure infringed on a woman's right to privacy under this section, and Planned Parenthood of Missoula v. St. (judgment of the First Judicial District, Lewis & Clark County, Dec. 29, 1999, declaring provisions of the Montana Abortion Control Act and the Woman's Right-to-Know Act unconstitutional under this section).

Standing of Health Care Providers to Litigate Privacy Right of Patient to Obtain Previability Abortion: In a case of first impression, the Supreme Court relied on federal law to decide that the statutes directed at health care providers in 37-20-103 and 50-20-109, which prohibit a physician assistant-certified from performing abortions, interfered with the normal functioning of the physician-patient relationship by criminalizing certain procedures. To establish standing to challenge government action: (1) the complaining party must clearly allege past, present, or threatened injury to a property right or civil right; and (2) the alleged injury must be distinguishable from the injury to the public generally but need not be exclusive to the complaining party. In this case, based on the closeness of the physician-patient relationship, the health care providers had standing, on behalf of their women patients, to assert the women's constitutional privacy right under this section to obtain a previability abortion from the health care provider of their choosing. Armstrong v. St., 1999 MT 261, 296 M 361, 989 P2d 364, 56 St. Rep. 1045 (1999), following Singleton v. Wulff, 428 US 106, 49 L Ed 2d 826, 96 S Ct 2868 (1976). See also Intermt. Planned Parenthood v. St. (Cause No. BDV 97-477) (June 29, 1998) (First Judicial District Court ruling (not appealed to Montana Supreme Court) that the law banning partial-birth abortion procedure infringed on a woman's right to privacy under this section, and Planned Parenthood of Missoula v. St. (judgment of the First Judicial District, Lewis & Clark County, Dec. 29, 1999, declaring provisions of the Montana Abortion Control Act and the Woman's Right-to-Know Act unconstitutional under this section).

Theology as Impermissible Basis on Which to Make Law or Interpret Constitution: In deciding that statutory provisions prohibiting a physician assistant-certified from performing abortions were an unconstitutional invasion of the right of privacy and personal procreative autonomy, the Supreme Court clarified that its opinion was not a comment on the merits of sectarian doctrine or on the deep and sincerely held beliefs, values, and convictions of those who either favor abortion or oppose it on moral or religious grounds. The right of expression aimed at
changing individual values and convictions and at fostering respect for the intrinsic value of all life is protected by the first amendment to the U.S. Constitution and by sections 5 and 7 of this article. However, the doctrine of separation of church and state that is also embodied in the first amendment and section 5 of this article makes theology an impermissible basis on which to make law or interpret the constitution. Religious arguments do not count as legal arguments. The cost of a person's enjoyment of fundamental constitutional rights does not permit the government's infringement of personal and procreative autonomy in the name of political ideology. Armstrong v. St., 1999 MT 261, 296 M 361, 989 P2d 364, 56 St. Rep. 1045 (1999). See also Interim. Planned Parenthood v. St. (Cause No. BDV 97-477) (June 29, 1998) (First Judicial District Court ruling (not appealed to Montana Supreme Court) that the law banning partial-birth abortion procedure infringed on a woman's right to privacy under this section, and Planned Parenthood of Missoula v. St. (judgment of the First Judicial District, Lewis & Clark County, Dec. 29, 1999, declaring provisions of the Montana Abortion Control Act and the Woman's Right-to-Know Act unconstitutional under this section).

Inmate Parole Files Public Files Subject to Right to Know Unless Specifically Limited by Privacy Concerns or Legitimate Penological Interest as Determined by Board of Pardons and Parole or Reviewing Court: The Supreme Court overturned a lower court decision denying inmates access to their parole files. The Supreme Court ruled that the Board of Pardons and Parole was a public agency, the inmates' records were public documents, and the public right to know applied to the records. The Supreme Court further held that individual privacy concerns or legitimate penological interests could limit public access to the parole files but that any such limitation would have to be determined on a case-by-case basis by the Board of Pardons and Parole or the reviewing court by determining if privacy concerns or penological interests clearly exceed the merits of public disclosure. Worden v. Bd. of Pardons & Parole, 1998 MT 168, 289 M 459, 962 P2d 1157, 55 St. Rep. 677 (1998).

Statute Unconstitutional as Applied -- Invasion of Right to Privacy: Gryczan and others, all of whom were homosexuals, brought a declaratory judgment action to determine whether 45-5-505, as applied, violated their right of privacy. After reviewing the case of Bowers v. Hardwick, 478 US 186 (1986), in which the U.S. Supreme Court held that the federal constitution does not confer a fundamental right on homosexuals to engage in sodomy, the Supreme Court noted that it had long held that the Montana Constitution affords citizens broader protection of a right to privacy than does the U.S. Constitution and that since privacy is explicit in the Montana Constitution, privacy is a fundamental right and any statute limiting the right must pass the strict scrutiny test. The Supreme Court then applied the test enunciated in Katz v. U.S., 389 US 347 (1967), and adopted by the Montana Supreme Court in Hastetter v. Behan, 196 M 280, 639 P2d 510 (1982), and found that "all adults have an expectation of privacy in noncommercial, consensual sexual conduct and that, while society may disapprove of homosexual conduct, society still recognizes that expectation of privacy, even concerning homosexual acts. The Supreme Court then determined that the interests advanced by the state in support of the constitutionality of the statute, the protection of public health by preventing the spread of the HIV-related virus, and the protection of public morals were not supported by the facts and were therefore not compelling state interests justifying an invasion of privacy. For these reasons, the Supreme Court determined the statute to be unconstitutional as applied to noncommercial, same-sex consensual sex between adults. Gryczan v. St., 283 M 433, 942 P2d 112, 54 St. Rep. 699 (1997), followed in Armstrong v. St., 1999 MT 261, 296 M 361, 989 P2d 364, 56 St. Rep. 1045 (1999).

Privacy Interest of Witness Held Sufficient for Closure of City Council Meeting -- "Generally Known" Incident: Goyen, the Chief of Police of Troy, was not notified of a meeting of the Troy City Council on May 10 at which an incident involving Goyen and a city gravel pile ("gravel-gate") was discussed. That meeting was closed at the request of the Mayor of Troy and at the request of a witness, Denton, who testified regarding indiscretions with Goyen in a patrol car. Later, after Goyen was discharged, he brought an action arguing that Denton's privacy interest was not at issue and that, in any event, the facts of her indiscretions with him were well known in the community, so much so that the demands of Denton's privacy could not outweigh the merits of public disclosure. The Supreme Court held that the plain meaning of 2-3-203 clearly allows a witness to assert the witness's privacy interest. Citing Missoulian v. Bd. of Regents of Higher Educ., 207 M 513, 675 P2d 962 (1984), the Supreme Court held that even harmless or generally known information is subject to constitutional protection and that Denton's relationship with Goyen, while known
by others, was private in nature and Denton therefore had a reasonable expectation of privacy that society would recognize. Goven v. Troy, 276 M 213, 915 P2d 824, 53 St. Rep. 353 (1996).

Elements of Invasion of Privacy Action: As set out in Rucinsky v. Hentchel, 266 M 502, 881 P2d 616, 51 St. Rep. 887 (1994), an invasion of privacy cause of action is defined as a wrongful intrusion into one's private activities in such a manner as to outrage or cause mental suffering, shame, or humiliation to a person of ordinary sensibilities. An attempted invasion of privacy is not the equivalent of an actual invasion of privacy. St. v. Kandarian, 268 M 408, 886 P2d 954, 51 St. Rep. 1381 (1994).

Statute of Limitations in Invasion of Privacy Action -- Summary Judgment Proper: In 1988, Hentchel told Rucinsky that he had tape recorded her telephone conversations. She asked to hear them, and he agreed to play them, but neither party pursued the issue further. In 1992, Hentchel's wife found the tapes and notified Rucinsky, who brought a claim for invasion of privacy. The District Court granted Hentchel's summary judgment motion on grounds that the 3-year statute of limitations for an action on a liability not founded on an instrument in writing, as set out in 27-2-204, had run. Under 27-2-102, a cause of action accrues when all of its elements exist or have occurred, the right to maintain an action is complete, and a court is authorized to accept jurisdiction. Rucinsky claimed that because a reasonable person would not have taken Hentchel seriously when he originally confessed that the taping had occurred, the statute of limitations was tolled until the tapes were discovered. The Supreme Court affirmed summary judgment. That Rucinsky chose not to believe the confession did not negate the existence of the elements of her cause of action in 1988. She had the right to the cause of action when she was put on notice that the tapes existed, and the cause of action began regardless of whether she was convinced of the success of the action. Rucinsky v. Hentchel, 266 M 502, 881 P2d 616, 51 St. Rep. 887 (1994).

False Light Invasion of Privacy: Plaintiff alleged that newspaper reports concerning him were the basis for a claim of false light invasion of privacy. False light invasion of privacy is (1) the publishing of a matter concerning another that (2) places the other before the public in a false light when (3) the false light in which the other is placed would be highly offensive to a reasonable person and (4) the actor knew of or acted in a reckless disregard as to the falsity of the publicized matter. Plaintiff failed to establish the falsity of the newspaper reports, so the District Court properly declined to recognize the claim. Lence v. Hagadone Inv., 258 M 433, 853 P2d 1230, 50 St. Rep. 601 (1993), followed in St. v. Kandarian, 268 M 408, 886 P2d 954, 51 St. Rep. 1381 (1994).

Refusal to Hook Up to City Water Supply Not Protected by Constitution: The defendants argued that a city ordinance requiring them to hook up to the city water system violated their right to privacy by denying them the freedom to choose the type of water they wanted to use. The Supreme Court held that the interest asserted did not involve matters so fundamentally affecting the defendants' rights as to invoke constitutional protection. The court also stated that nothing prevented the defendants from using their well water after having complied with the city ordinance because the ordinance only required hooking up to the system; the ordinance did not mandate using the city's water. Ennis v. Stewart, 247 M 355, 807 P2d 179, 48 St. Rep. 228 (1991), distinguished in Gryczan v. St., 283 M 433, 942 P2d 112, 54 St. Rep. 699 (1997).

Discharge of Police Officer Based on Off-Duty Activities: The constitutional right of privacy does not completely protect a police officer from discharge based solely upon his off-duty activities. The State has an overriding and compelling interest in protecting the public and preserving the integrity of the police department, and this interest overrode respondent's right to privacy. In re Raynes, 215 M 484, 698 P2d 856, 42 St. Rep. 569 (1985).

University President Evaluation Protected: The Missoulian challenged the closure by the Board of Regents of a job performance evaluation of the presidents of the six units of the university system. The court applied a two-part test to determine whether the presidents have a constitutionally protected privacy interest: (1) whether the presidents have a subjective or actual expectation of privacy, and (2) whether society is willing to recognize that expectation as reasonable. The first part of the test is satisfied because the presidents were assured the evaluation would be confidential, as were others providing input to the Regents. The second part of the test is also satisfied to assure an unabashed and candid evaluation of presidents. University presidents' job performance evaluations were matters of individual privacy protected by this section. Missoulian v. Bd. of Regents, 207 M 513, 675 P2d 962, 41 St. Rep. 110 (1984), followed in Flesh v. Bd. of Regents.
Voluntary Statements Made to Civilians in Criminal Case -- No Invasion of Privacy: On two occasions while the defendant and his stepson were alone, the stepson received serious injuries. On both occasions the defendant made statements to his wife and to several doctors explaining how the injuries occurred. The defendant was charged with aggravated assault and filed a motion to suppress his statements. The defendant contended that the statements violated his right of privacy guaranteed by the Montana Constitution. The court found that there was no element of surreptitious obtaining of the information. Additionally, constitutional provisions on right of privacy permit its invasion upon a showing of a compelling state interest. That compelling state interest is clearly shown in child abuse cases by the declaration of policy contained in 41-3-101. St. v. Hall, 183 M 511, 600 P2d 1180 (1979).

Compelling State Interest in Protecting Against Burglary: When police officers discovered marijuana after entering defendant's home believing a burglary was in progress, the Supreme Court rejected defendant's contention, based on the "right of privacy", that there is no compelling state interest justifying intrusion into a private home. Such compelling state interest exists by virtue of state enforcement of its criminal laws for the benefit and protection of other fundamental rights of its citizens as in the protection of a citizen's home and its contents from unlawful intrusion. State ex rel. Zander v. District Court, 180 M 548, 591 P2d 656 (1979).

Expectation to Be Reasonable: Marijuana plants were left on plywood sheets in an open field on defendant's abandoned ranch. There were no locked gates on the property, and it was not posted. The court held that although defendant may have had subjective expectations of privacy in the property, those expectations were not objectively reasonable. The marijuana plants were not in an area where any reasonable expectation of privacy existed, so a search warrant was not required. St. v. Charvat, 175 M 267, 573 P2d 660 (1978).

Discharge of Probationary State Employee Based Upon His Private Life: Dismissal of drug abuse consultant based upon his personal lifestyle is not an infringement upon his substantive due process right of privacy as he was engaged in counseling people with personal problems, thus his own personal philosophies became relevant to his job performance. What an employee does in his private life should not be his employer's concern unless, as in this case, it can be shown to affect in some degree his efficiency in the performance of his duties. Storch v. Bd. of Directors, 169 M 176, 545 P2d 644 (1976).

County Employee Time Records Subject to Public Disclosure:

County time records that show an employee's name, the department for which the employee works, and the hours worked, including claims for vacation, holiday, and sick leave pay, are subject to public disclosure, involving only a slight intrusion into individual privacy but a substantial public interest in having access to the records. 44 A.G. Op. 32 (1992).

Buyer's Affidavit and Certification Subject to Public Disclosure:

The buyer's affidavit and certification submitted to the Board of Housing pursuant to the mortgage credit certificate program is subject to public disclosure. 43 A.G. Op. 25 (1989).

Availability of Payroll Record Information -- Social Security Number Excepted:

Applying the balancing test set out in 42 A.G. Op. 64 (1988), the Attorney General concluded that payroll record information reported to the Department of Highways (now Department of Transportation), including the names, addresses, and wages of private employees working on a publicly funded project, is subject to public disclosure. Social security numbers of those employees are not subject to public disclosure. 43 A.G. Op. 6 (1989).

Criminal Investigative Information -- Balancing Test:

The interests of the public's right to know and an individual's right of privacy must be balanced on a case-by-case basis by the custodian of the criminal justice information sought in determining whether criminal investigative information contained in an initial offense report or an initial arrest record should be publicly disseminated. 42 A.G. Op. 119 (1988).

Original Documents Submitted to Retirement Division Not Subject to Public Inspection for Mailing
List Purposes:

Original documents submitted by applicants to the Public Employees' Retirement Division of the Department of Administration contain private information about third parties and thus are not open to public inspection for the purpose of compiling a mailing list. 42 A.G. Op. 64 (1988).

Disclosure of Merit Pay of School District Administrators:

The administrators of a school district do not have a constitutionally protected right to privacy regarding the amount of merit pay awarded to them pursuant to the district's Leadership Evaluation and Compensation Plan. Therefore, the amounts should be disclosed to the public. 41 A.G. Op. 35 (1985).

Constitution Law Review Articles

Restoring Private to Privacy, Renz, 64 Mont. L. Rev. 385 (2003).


The Issues of E-Mail Privacy and Cyberspace Personal Jurisdiction: What Clients Need to Know About Two Practical Constitutional Questions Regarding the Internet, Kende, 63 Mont. L. Rev. 301 (2002).


Comments on Government Censorship and Secrecy, Elison & Elison, 55 Mont. L. Rev. 175 (1994).


Constitution Collateral References

Abortion + 1; Action + 2; Arrest + 63.4(13); Constitutional Law + 82(7), (10), 274(5); Courts + 89; Criminal Law + 394.1, 1222; Damages + 48, 163(1); Disorderly Conduct + 7; Drugs and Narcotics + 43; Indictment and Information + 114, 125(1); Injunction + 96; Officers + 19, 69.7, 110; Pleadings + 8(3), 207, 225(2); Prisons + 4(6); Records + 58; Searches + 7; Sodomy + 1; Telecommunications + 439, 494, 495; Torts + 3, 8, 17, 26 through 28; Trade Regulation + 482.

14 C.J.S. Civil Rights § § 2, 14 through 17; 16B C.J.S. Constitutional Law § § 630 through 648; 77
MT CONST Art. 2, § 10

C.J.S. Right of Privacy § § 1 through 8; 79 C.J.S. Searches and Seizures § § 3, 128, 132, 133.


Reasonable expectation of privacy in tent or campsite. 66 ALR 5th 373.

State statutes or regulations expressly governing disclosure of fact that person has tested positive for human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). 12 ALR 5th 149.

"Caller ID" system, allowing telephone call recipient to ascertain number of telephone from which call originated, as violation of right to privacy, wiretapping statute, or similar protections. 9 ALR 5th 553.

Bank's liability, under state law, for disclosing financial information concerning depositor or customer. 81 ALR 4th 377.

Search and seizure of telephone company records pertaining to subscriber as violation of subscriber's constitutional rights. 76 ALR 4th 536.

Search and seizure: reasonable expectation of privacy in public restroom. 74 ALR 4th 508.

Intrusion by news-gathering entity as invasion of right of privacy. 69 ALR 4th 1059.

Invasion of privacy by a clergyman, church, or religious group. 67 ALR 4th 1086.

Discovery of identity of blood donor. 56 ALR 4th 755.

Eavesdropping on extension telephone as invasion of privacy. 49 ALR 4th 430.

Physician's tort liability for unauthorized disclosure of confidential information about patient. 48 ALR 4th 668.

Computer as nuisance. 45 ALR 4th 1212.

What constitutes "single publication" within meaning of single publication rule affecting action for libel and slander, violation of privacy, or similar torts. 41 ALR 4th 541.

Retailer's surveillance of fitting or dressing rooms as invasion of privacy. 38 ALR 4th 954.

Right of member of nonprofit association or corporation to possession, inspection, or use of membership list. 37 ALR 4th 1206.

Limitation of actions: invasion of right of privacy. 33 ALR 4th 479.

Reasonable expectation of privacy in contents of garbage or trash receptacle. 28 ALR 4th 666.

Permissible warrantless surveillance, under state communications interception statute, by state or local law enforcement officer or one acting in concert with officer. 27 ALR 4th 449.

What constitutes personal matters exempt from disclosure by invasion of privacy exemption under state freedom of information act. 26 ALR 4th 666.

Permissible surveillance, under state communications interception statute, by person other than state or local law enforcement officer or one acting in concert with officer. 24 ALR 4th 1208.

Validity and construction of orders and enactments requiring public officers and employees, or candidates for office, to disclose financial condition, interests, or relationships. 22 ALR 4th 237.

Validity of state statutes and regulations limiting or restricting public funding for abortions sought by indigent women. 20 ALR 4th 1166.

Validity of statute making sodomy a criminal offense. 20 ALR 4th 1009.

Validity of law criminalizing wearing dress of opposite sex. 12 ALR 4th 1249.

Validity and construction of state Fair Credit Reporting Act. 12 ALR 4th 294.

Right to publicize or commercially exploit deceased person's name or likeness as inheritable. 10 ALR 4th 1193.

Use of electronic sensing device to detect shoplifting as unconstitutional search and seizure. 10

Validity, construction, and effect of state laws requiring public officials to protect confidentiality of income tax returns or information. 1 ALR 4th 959.

Telephone company's liability for disclosure of number or address of subscriber holding unlisted number. 1 ALR 4th 218.

Propriety of publishing identity of sexual assault victim. 86 ALR 3d 80.

Publication of address as well as name of person as invasion of privacy. 84 ALR 3d 1159.

Television, right of privacy with respect to. 57 ALR 3d 8; 56 ALR 3d 386; 15 ALR 2d 785.

Threatening, instituting or prosecuting legal action as invasion of right of privacy. 42 ALR 3d 865.

Public disclosure of person's indebtedness as invasion of privacy. 33 ALR 3d 154.

Invasion of privacy by use of plaintiff's name or likeness for nonadvertising purposes. 30 ALR 3d 203.

Invasion of privacy by use of plaintiff's name or likeness in advertising. 23 ALR 3d 865.

Right of privacy, generally. 23 ALR 3d 865; 11 ALR 3d 1296; 14 ALR 2d 750.

Physician's tort liability, apart from defamation, for unauthorized disclosure of confidential information about patient. 20 ALR 3d 1109.

Invasion of right of privacy by merely oral declarations. 19 ALR 3d 1318.

Invasion of privacy by publication dealing with one other than plaintiff. 18 ALR 3d 873.

Investigations and surveillance, shadowing and trailing, as violation of right of privacy. 13 ALR 3d 1025.

Eavesdropping as violating right of privacy. 11 ALR 3d 1296.

Conflict of laws with respect to the "single publication" rule as to defamation, invasion of privacy, or similar torts. 58 ALR 2d 650.

Blood grouping tests as violation of right of privacy. 46 ALR 2d 1016.

Fingerprint, palm print, or bare footprint evidence, right to privacy as affected by. 28 ALR 2d 1141.

Right of Privacy -- Implementing Article II, Section 10, of the Montana Constitution, Interim Report, Montana Legislative Council (1975-76). MT CONST Art. 2, § 10, MT CONST Art. 2, § 10

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
(1) Local government, state, and federal law enforcement and correctional agencies may use any detention center for the confinement of arrested persons and the punishment of offenders, under conditions imposed by law and with the consent of the governing body responsible for the detention center.

(2) (a) If a person is confined in a detention center by an arresting agency not responsible for the operation of the detention center, the costs of holding the person in confinement must be paid by the arresting agency at a rate that is agreed upon by the arresting agency and the detention center and that covers the reasonable costs of confinement, excluding capital construction costs, except as provided in 7-32-2245 or subsection (2)(b) of this section.

(b) If a city or town commits a person to the detention center of the county in which the city or town is located for a reason other than detention pending trial for or detention for service of a sentence for violating an ordinance of that city or town, the costs must be paid by the county, except as provided in 7-32-2245. If the department of corrections is the arresting agency and the inmate is a probation violator, the costs must be paid by the county in which the district court that retains jurisdiction over the inmate is located, except as provided in 7-32-2245.

(c) Payments must be made to the government unit responsible for the detention center or to the administrator operating a private detention center under an agreement provided for in 7-32-2201, upon presentation of a claim to the arresting agency.

(3) If a person is a fugitive from justice from an out-of-state jurisdiction, the costs, including medical expenses, of holding the person in a detention center pending extrardition must be paid by the out-of-state jurisdiction.
A sentencing hearing represents the only common date by which the criminal justice system can definitely measure when legal and financial responsibility for an inmate shifts from a county to the state. Oral pronouncement of sentence from the bench in the presence of a defendant constitutes final judgment (see St. v. Lane, 1998 MT 76, 288 M 286, 957 P2d 9 (1998)). Once sentenced, an inmate is considered to be in the legal custody of the Department of Corrections, even though a local or regional detention center may serve as a place of temporary detention until the inmate can be placed by the Department. Therefore, upon oral pronouncement of sentence that transfers legal custody of an inmate to the Department, the financial responsibility for the inmate transfers to the Department as well. 49 A.G. Op. 13 (2001).
MONTANA CODE ANNOTATED
TITLE 7. LOCAL GOVERNMENT
CHAPTER 32. LAW ENFORCEMENT
PART 22. DETENTION CENTERS

7-32-2245. Payment of confinement and medical costs by inmate

(1) An inmate found by the sentencing court to have the ability to pay is liable for the costs, including actual medical costs, of the inmate's confinement in a detention center. The rate for confinement costs must be determined in accordance with 46-18-403. Confinement costs, other than actual medical costs, must be ordered by the court and must be paid in advance of confinement and prior to payment of any fine.

(2) If an inmate requires medical treatment, the inmate is responsible for medical costs associated with:

(a) preexisting conditions;

(b) self-inflicted injuries while in custody;

(c) injuries incurred while in custody if the injuries are not the result of negligent or intentionally torturous acts committed by the detention center administrator or a member of the administrator's staff;

(d) injuries incurred during the commission of a crime or while unlawfully resisting arrest or attempting to avoid an arrest; and

(e) any other injuries or illnesses that are not the responsibility of other entities as provided in 7-32-2224 and 7-32-2242(3).

(3) (a) If an inmate is found to be able to pay for the inmate's medical costs, as provided in subsections (1) and (2), the health care provider who treats the inmate shall collect the cost of the treatment from the inmate or the detention center administrator may arrange with the health care provider to pursue reimbursement from a third-party payor for the services provided.

(b) If the health care provider is unable to collect from the inmate or third-party payor within 120 days from the date of the service, the county is responsible for reimbursing the health care provider for the services at:

(i) the medicaid reimbursement rate or at a rate that is 70% of the provider's customary charges, whichever is greater; or

(ii) a negotiated rate.

(c) If the health care provider is reimbursed by the inmate or the third-party payor after the provider has been reimbursed by the county, the provider shall refund to the county the amount that the provider had been paid by the county for the services provided to the inmate.

(4) Inability to pay may not be a factor in providing necessary medical care for an inmate.

(5) This section does not restrict an inmate's right to use a third-party payor.

(6) If a city or town is the arresting agency and commits a person to the detention center of the county in which the city or town is located, the inmate is responsible for the inmate's medical expenses and the provisions of this section apply.

History: En. Sec. 5, Ch. 461, L. 1989; amd. Sec. 3, Ch. 388, L. 1995; amd. Sec. 2, Ch. 579, L. 2003.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

2003 Amendment: Chapter 579 substituted (2) concerning inmate responsibility for medical costs for former text that read: "An inmate is responsible for the actual costs of medication, medical services, or hospitalization while the inmate is detained in a detention center. Inability to pay may not be a factor in providing necessary medical care for an inmate. This section does not restrict an inmate's right to use a third-party payor"; inserted (3) concerning collection of inmate's medical costs; inserted (4) concerning inability to pay; inserted (5) concerning right to use third-party payor; and inserted (6) concerning city or town as arresting agency. Amendment effective May 5, 2003.

1995 Amendment: Chapter 388 in (1), in first sentence after "costs", inserted "including actual medical costs", in second sentence substituted "The
rate for confinement costs must be determined in accordance with 46-18-403 for "The rate at which the inmate must pay the costs must be established at the sentencing hearing", and inserted third sentence concerning payment of court-ordered confinement costs; inserted (2) concerning an inmate's responsibility for medical costs; and made minor changes in style. Amendment effective April 12, 1995.

Case Notes

Conditions Imposed in Written Judgment and Sentence Different From Those Imposed in Oral Sentence -- Lane, Waters, and Simpson Reviewed -- Test to Determine Which New Conditions Lawful or Unlawful -- Payment of Restitution and Costs: Johnson was sentenced orally for writing bad checks and later contended that four of the conditions imposed in the written judgment and sentence by the District Court were unlawful under St. v. Lane, 1998 MT 76, 288 M 286, 957 P2d 9 (1998), because they were not announced orally when she was sentenced in open court. The Supreme Court reviewed its decisions in St. v. Waters, 1999 MT 229, 296 M 101, 987 P2d 1142 (1999), and St. v. Simpson, 1999 MT 259, 296 M 335, 989 P2d 361 (1999), and reasoned that a written sentence would be held unlawful only if it substantively increased the defendant's loss of liberty or the defendant's sacrifice of property. Under this test, the Supreme Court held that two of the four penalties not mentioned by the District Court in its oral pronouncement of Johnson's sentence were unlawful, those being the restitution ordered to the Missoula County jail of money expended for Johnson's medical care and the requirement that Johnson pay for the costs of her prosecution in District Court. The Supreme Court held that the other two parts of the written sentence, the requirement that Johnson make restitution from money earned in prison and the imposition of certain "civil" restrictions as conditions of Johnson's suspended sentence, such as the requirement that Johnson stay out of gambling casinos, were lawfully imposed because they did not increase the amount of money that Johnson was ordered to pay or increase Johnson's deprivation of liberty in addition to those penalties imposed orally. The requirement for payment from prison earnings only specified where the money was to come from, and the "civil" restrictions were largely mentioned by the District Court at Johnson's sentencing hearing. St. v. Johnson, 2000 MT 290, 302 M 265, 14 P3d 480, 57 St. Rep. 1225 (2000).

County Primarily Responsible for Postarrest Medical Care:

A county is primarily responsible to third-party providers for postarrest medical care given to a person who is ultimately charged with a violation of state law. Following conviction, an inmate who has the means to pay is responsible for the ultimate payment of medical costs pursuant to this section, and a county at that point may seek recovery from another party pursuant to state law. 47 A.G. Op. 2 (1997).

MCA 7-32-2245, MT ST 7-32-2245

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
The physician, nurse, or other person licensed to practice a health care profession treating the victim of a gunshot wound or stabbing shall make a report to a law enforcement officer by the fastest possible means. Within 24 hours after initial treatment or first observation of the wound, a written report shall be submitted, including the name and address of the victim, if known, and shall be sent by regular mail.


LIBRARY REFERENCES

Health 196.
Westlaw Key Number Search: 198Hk196.
C.J.S. Physicians, Surgeons, and Other Health Care Providers §§ 71, 77.
MCA 35-21-810, MT ST 35-21-810

MONTANA CODE ANNOTATED
TITLE 35. CORPORATIONS, PARTNERSHIPS, AND ASSOCIATIONS
CHAPTER 21. MAUSOLEUM AND COLUMBARIUM AUTHORITIES
PART 8. MAUSOLEUM-COLUMBARIUM AUTHORITIES

35-21-810. Disposition of remains -- liability

(1) The right to control the disposition of the remains of a deceased person, unless other directions have been given by the decedent, vests in, and the duty of interment and the liability for the reasonable cost of interment of the remains devolves upon, the following in the order named:

(a) a spouse;

(b) a majority of adult children;

(c) a parent;

(d) a close relative of the decedent; or

(e) in the absence of a person listed in subsections (3)(a) through (3)(d), a personal representative, a public administrator, the deceased through a preneed authorization, or others as designated by the board of funeral service by rule.

(2) The liability for the reasonable cost of interment devolves jointly and severally upon all kin of the decedent listed in subsection (1) in the same degree of kindred and upon the estate of the decedent.

(3) A person signing an authorization for the interment of any remains warrants the truthfulness of any fact set forth in the authorization, the identity of the person whose remains are sought to be interred, and the person's authority to order the interment. The person signing the authorization is personally liable for all damage occasioned by or resulting from breach of the warranty.

(4) The mausoleum-columbarium authority may inter any remains upon the receipt of a written authorization of a person representing to be a person who has acquired the right to control the disposition of the remains. A mausoleum-columbarium authority is not liable for interring pursuant to the authorization unless it has actual notice that presentation is untrue.

History: En. Sec. 6, Ch. 283, L. 1999.

<General Materials (GM) - References, Annotations, or Tables>

MCA 35-21-810, MT ST 35-21-810

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
37-2-201. Nonliability -- evidential privilege -- application to nonprofit corporations

(1) A member of a utilization review or medical ethics review committee of a hospital or long-term care facility or of a professional utilization committee, peer review committee, medical ethics review committee, or professional standards review committee of a society composed of persons licensed to practice a health care profession is not liable in damages to any person for any action taken or recommendation made within the scope of the functions of the committee if the committee member acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts known to the member after reasonable effort to obtain the facts of the matter for which the action is taken or a recommendation is made.

(2) The proceedings and records of professional utilization, peer review, medical ethics review, and professional standards review committees are not subject to discovery or introduction into evidence in any proceeding. However, information otherwise discoverable or admissible from an original source is not to be construed as immune from discovery or use in any proceeding merely because it was presented during proceedings before the committee, nor is a member of the committee or other person appearing before it to be prevented from testifying as to matters within the individual's knowledge, but the individual may not be questioned about the individual's testimony or other proceedings before the committee or about opinions or other actions of the committee or any member of the committee.

(3) This section also applies to any member, agent, or employee of a nonprofit corporation engaged in performing the functions of a peer review, medical ethics review, or professional standards review committee.


LIBRARY REFERENCES

Health 274.
Privileged Communications and Confidentiality 422.
Westlaw Key Number Searches: 198Hk274; 311Hk422.

RESEARCH REFERENCES

Treatises and Practice Aids


Current through all 2009 legislation

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37-2-301. Duty to report cases of communicable disease

(1) If a physician or other practitioner of the healing arts examines or treats a person who the physician or other practitioner believes has a communicable disease or a disease declared reportable by the department of public health and human services, the physician or other practitioner shall immediately report the case to the local health officer. The report must be in the form and contain the information prescribed by the department.

(2) A person who violates the provisions of this section or rules adopted by the department under the provisions of this section is guilty of a misdemeanor. On conviction, the person shall be fined not less than $10 or more than $500, imprisoned for not more than 90 days, or both. Each day of violation constitutes a separate offense. Fines, except those collected by a justice's court, must be paid to the county treasurer of the county in which the violation occurs.

History: (1)En. Sec. 91, Ch. 197, L. 1967; Sec. 69-4514, R.C.M. 1947; (2)En. Sec. 96, Ch. 197, L. 1967; amd. Sec. 108, Ch. 349, L. 1974; amd. Sec. 3, Ch. 273, L. 1975; Sec. 69-4519, R.C.M. 1947; R.C.M. 1947, 69-4514, 69-4519(part); amd. Sec. 21, Ch. 557, L. 1987; amd. Sec. 58, Ch. 418, L. 1995; amd. Sec. 87, Ch. 546, L. 1995.

"department of health and environmental sciences"; and made minor changes in style. Amendment effective July 1, 1995.

Transition: Section 499, Ch. 418, L. 1995, provided: "The provisions of 2-15-131 through 2-15-137 apply to [this act]."

Saving Clauses: Section 503, Ch. 418, L. 1995, was a saving clause.

Section 571, Ch. 546, L. 1995, was a saving clause.

1987 Amendment: In last sentence of (2), after "Fines", inserted "except those collected by a justice's court".

Cross-References
Collection and disposition of fines, penalties, forfeitures, and fees, 3-10-601.

Collateral References
Health + 25, 37 through 43.

39A C.J.S. Health and Environment § § 22, 48 through 51.


Vaccination of school children, 93 ALR 1413.

MCA 37-2-301, MT ST 37-2-301

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
C


MONTANA CODE ANNOTATED
TITLE 37. PROFESSIONS AND OCCUPATIONS
CHAPTER 19. MORTICIANS AND FUNERAL DIRECTORS
PART 1. GENERAL
37-19-101. Definitions

Unless the context requires otherwise, in this chapter, the following definitions apply:

(1) "Arrangements" includes:

(a) planning the details of funeral service, including time of service, type of service, and, if requested, acquiring the services of clergy;
(b) obtaining the necessary information for filing death certificates;
(c) comparing or discussing prices, including merchandise prices and financial arrangements; and
(d) providing for onsite direction and coordination of participants and onsite direction, coordination, and facilitation at funeral, graveside, or memorial services or rites.

(2) "At-need" arrangements means arrangements made by an authorized person on behalf of a deceased.

(3) "Authorizing agent" means a person legally entitled to order the final disposition, including burial, cremation, entombment, donation to medical science, or other means, of human remains. An authorizing agent is, in order of preference:

(a) a spouse;
(b) a majority of adult children;
(c) a parent;
(d) a close relative of the deceased; or
(e) in the absence of a person or persons listed in subsections (1)(a) through (1)(d), a personal representative, a public administrator, the deceased through a preneed authorization, or others as designated by board rule.

(4) "Board" means the board of funeral service provided for in 2-15-1743.

(5) "Branch establishment" means a separate facility that may or may not have a suitable visitation room or preparation room and that is owned by, a subsidiary of, or otherwise financially connected to or controlled by a licensed mortuary.

(6) "Cemetery" means any land or structure in this state dedicated to and used or intended to be used for interment of cremated remains or human remains. It may be any one or a combination of a burial park for earth interments, a mausoleum for crypt or niche interments, or a columbarium.

(7) "Cemetery company" means an individual, partnership, corporation, or association that:

(a) owns or controls cemetery lands or property and conducts the business of a cemetery; or
(b) applies to the board to own or control cemetery lands or property and conduct the business of a cemetery.

(8) "Closed container" means a container in which cremated remains can be placed and enclosed in a manner that prevents leakage or spillage of cremated remains or entrance of foreign material.

(9) "Columbarium" means a room or space in a building or structure used or intended to be used for the interment of cremated remains.

(10) "Cremated remains" means all human remains recovered after the completion of the cremation, including pulverization that leaves only bone fragments reduced to unidentifiable dimensions.

(11) "Cremation" means the technical process, using heat, that reduces human remains to bone fragments. The reduction takes place through heat and evaporation.

(12) "Cremation chamber" means the enclosed space within which the cremation process takes place. Cremation chambers of crematoriums licensed by this chapter must be used exclusively for the cremation of human remains.

(13) "Cremation container" means the container in which the human remains are placed in the cremation chamber for a cremation. A cremation container must meet substantially all of the following standards:
(a) be composed of readily combustible materials suitable for cremation;

(b) be able to be closed in order to provide a complete covering for the human remains;

(c) be resistant to leakage and spillage;

(d) be rigid enough for handling with ease; and

(e) be able to provide protection for the health, safety, and integrity of crematory personnel.

(14) "Crematory" means the building or portion of a building that houses the cremation chamber and the holding facility.

(15) "Crematory operator" means the person in charge of the licensed crematory facility.

(16) "Crematory technician" means an employee of a crematory facility who is trained to perform cremations and is licensed by the board.

(17) "Crypt" means a chamber of sufficient size to inter the remains of a deceased person.

(18) "Department" means the department of labor and industry provided for in Title 2, chapter 15, part 17.

(19) "Embalming" means:

(a) obtaining burial or removal permits or assuming other duties incidental to the practice of embalming;

(b) disinfecting and preserving or attempting to preserve dead human bodies in their entirety or in parts by the use of chemical substances, fluids, or gases ordinarily intended for that use by introducing the chemical substances, fluids, or gases into the body by vascular or hypodermic injection or by direct introduction into the organs or cavities; and

(c) restorative art.

(20) "Funeral directing" includes:

(a) supervising funerals;

(b) the making of preneed or at-need contractual arrangements for funerals;

(c) preparing dead bodies for burial, other than by embalming;

(d) maintaining a mortuary for the preparation, disposition, or care of dead human bodies; and

(e) representing to the public that one is a funeral director.

(21) "Holding facility" means an area within or adjacent to the crematory facility designated for the retention of human remains prior to cremation that must:

(a) comply with any applicable public health law;

(b) preserve the dignity of the human remains;

(c) recognize the health, safety, and integrity of the crematory operator and crematory personnel; and

(d) be secure from access by anyone other than authorized personnel.

(22) "Human remains" means the body of a deceased person or part of a body or limb that has been removed from a living person, including the body, part of a body, or limb in any stage of decomposition.

(23) "Interment" means any lawful disposition of cremated remains or human remains.

(24) (a) "Intern" means a person who has met the educational and testing requirements for a license to practice mortuary science in Montana, has been licensed by the board as an intern, and is engaged in the practice of mortuary science under the supervision of a licensed mortician.

(b) For the purposes of this subsection (24), "supervision" means the extent of oversight that a mortician believes an intern requires based upon the training, experience, judgment, and professional development of the intern.

(25) "Lot" or "grave space" means a space in a cemetery used or intended to be used for interment.

(26) "Mausoleum" means a community-type room or space in a building or structure used or intended to be used for the interment of human remains in crypts or niches.

(27) "Mortician" means a person licensed under this chapter to practice mortuary science.
(28) (a) "Mortuary" means a place of business licensed by the board, located in a building or portion of a building having a specific street address or location, containing but not limited to a suitable room for viewing or visitation and a preparation room, and devoted exclusively to activities that are related to the preparation and arrangements for funerals, transportation, burial, or other disposition of dead human bodies.

(b) The term includes conducting activities from the place of business referred to in subsection (28)(a) that are incidental, convenient, or related to the preparation of funeral or memorial services or rites or the transportation, burial, cremation, or other disposition of dead human bodies in any area where those activities may be conducted.

(29) "Mortuary science" means the profession or practice of funeral directing and embalming.

(30) "Niche" means a space in a columbarium or mausoleum used or intended to be used for the interment of the cremated remains or human remains of one or more deceased persons.

(31) "Perpetual care and maintenance" means continual and proper maintenance of cemetery buildings, grounds, and lots or grave spaces.

(32) "Preneed arrangements" means arrangements made with a licensed funeral director or licensed mortician by a person on the person's own behalf or by an authorized individual on the person's behalf prior to the death of the person.

(33) "Temporary container" means a receptacle for cremated remains that is usually made of cardboard, plastic film, or similar material designed to hold the cremated remains until an urn or other permanent container is acquired.

(34) "Urn" means a receptacle designed to permanently encase the cremated remains.

History: En. Sec. 1, Ch. 41, L. 1963; amd. Sec. 260, Ch. 350, L. 1974; R.C.M. 1947, 66-2701; amd. Sec. 3, Ch. 274, L. 1981; amd. Sec. 1, Ch. 298, L. 1989; amd. Sec. 3, Ch. 38, L. 1993; amd. Sec. 2, Ch. 52, L. 1997; amd. Sec. 1, Ch. 336, L. 1999; amd. Sec. 128, Ch. 483, L. 2001; amd. Sec. 40, Ch. 126, L. 2005.

Compiler's Comments

2005 Amendment: Chapter 126 in definition of arrangements in (b) at end after "certificates" deleted "and obtaining burial-transit permits". Amendment effective July 1, 2005.

2001 Amendment: Chapter 483 in definition of department substituted reference to department of labor and industry for reference to department of commerce and substituted "part 17" for "part 18". Amendment effective July 1, 2001.

1999 Amendment: Chapter 336 inserted definitions of arrangements, at-need, branch establishment, intern, and preneed arrangements; in definition of authorizing agent after "order" substituted "the final disposition, including burial, cremation, entombment, donation to medical science, or other means" for "the cremation"; substituted definition of embalming for former language that read: "means the preservation and disinfection of the dead human body by application of chemicals, externally, internally, or both"; substituted definition of mortuary for former language that read: "means the place of business used for the care and preparation for burial or transportation of dead human bodies or a place where a person represents that the person is engaged in the profession of mortuary science or funeral directing"; and made minor changes in style. Amendment effective October 1, 1999.

1997 Amendment: Chapter 52 inserted definitions of cemetery, cemetery company, columbarium, crypt, interment, lot or grave space, mausoleum, niche, and perpetual care and maintenance; and made minor changes in style.

1993 Amendment: Chapter 38 inserted definitions of authorizing agent, closed container, cremated remains, cremation, cremation chamber, cremation container, crematory, crematory operator, crematory technician, holding facility, human remains, temporary container, and urn, in definition of Board substituted "funeral service" for "morticians", and at end of definition of funeral directing deleted "or undertaker"; and made minor changes in style. Amendment effective February 10, 1993.

1989 Amendment: In (4)(a) inserted "including the making of preneed or at-need contractual arrangements for funerals". Amendment effective
March 24, 1989.

1989 Statement of Intent: The statement of intent attached to Ch. 298, L. 1989, provided: "A statement of intent is required for this bill because it grants authority to the board of morticians to adopt rules for:

(1) the imposition of fines in disciplinary actions for unprofessional conduct. Fines may be levied for any conduct for which a mortician's or funeral director's license could be revoked or suspended.

(2) the setting of standards for operating mortuary facilities to assure adherence to sanitary and safety provisions;

(3) the collection of fees and charges for mortuaries, which fees or charges must be commensurate with costs incurred for the services; and

(4) the establishment of reasonable application forms for operation of a new mortuary and transfer fees required to allow the transfer of a license to a new facility."

1981 Amendment: Substituted "department of commerce" for "department of professional and occupational licensing" in (2); changed internal references to the department and the board.


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END OF DOCUMENT
MCA 37-19-302, MT ST 37-19-302

MONTANA CODE ANNOTATED
TITLE 37. PROFESSIONS AND OCCUPATIONS
CHAPTER 19. MORTICIANS AND FUNERAL DIRECTORS
PART 3. LICENSING OF MORTICIANS AND FUNERAL DIRECTORS
37-19-302. License required for practice of mortuary science -- qualifications of applicants

(1) The practice of embalming or mortuary science by anyone who does not hold a mortician's license issued by the board is prohibited. A person 18 years of age or older wishing to practice mortuary science in this state must apply to the board on the form and in the manner prescribed by the board.

(2) To qualify for a mortician's license, a person must:

(a) be of good moral character;

(b) present evidence of having satisfactorily completed 90 quarter credits or the equivalent of study at an accredited college or university;

(c) in addition to the 90 quarter credits or the equivalent of study required in subsection (2)(b), have graduated with a diploma from an accredited college of mortuary science;

(d) pass an examination prescribed by the board; and

(e) serve a 1-year internship under the supervision of a licensed mortician in a licensed mortuary after passing the examination provided for in subsection (2)(d).

(3) A person who fails the examination required in subsection (2)(d) may retake it under conditions prescribed by rule of the board.

History: En. Sec. 8, Ch. 41, L. 1963; amd. Sec. 9, Ch. 168, L. 1971; amd. Sec. 265, Ch. 350, L. 1974; R.C.M. 1947, 66-2708; amd. Sec. 4, Ch. 378, L. 1981; amd. Sec. 1, Ch. 510, L. 1985; amd. Sec. 22, Ch. 224, L. 2003.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

2003 Amendment: Chapter 224 in (1)(e) after "mortuary" deleted "in Montana". Amendment effective July 1, 2003.

Severability: Section 34, Ch. 224, L. 2003, was a severability clause.

Saving Clause: Section 35, Ch. 224, L. 2003, was a saving clause.

1985 Amendment: In first sentence of (1) substituted "board" for "department", and inserted last sentence of (1) requiring person 18 or older to apply; at beginning of (2)(b) substituted "present evidence of having satisfactorily completed 90 quarter credits or the equivalent of study" for "have graduated from an accredited college of mortuary science and have satisfactorily completed 2 academic years" and at end of (2)(b) deleted "or have experience considered equivalent by the board"; inserted (2)(c) requiring an applicant to have graduated from an accredited college of mortuary science; in (2)(e) before "mortician" inserted "licensed" and at end inserted "after passing the examination provided for in subsection (2)(d)"; and inserted (3) allowing applicant who fails examination to retake it.

Severability: Section 5, Ch. 510, L. 1985, was a severability section.

Statement of Intent: The statement of intent attached to Ch. 510, L. 1985, provided: "It is the intent of the legislature by this bill that the board of morticians be delegated authority to adopt rules to:

(1) determine under what conditions unsuccessful applicants for licenses to practice mortuary science may retake the appropriate examination;

(2) grant special consideration as to recognition of internship qualifications in hardship cases; and

(3) define "unprofessional conduct" for license disciplinary purposes."

1981 Amendment: Added "or have experience considered equivalent by the board" at the end of (2).
MCA 37-19-302, MT ST 37-19-302

Administrative Rules

ARM 24.147.402 Applications.

ARM 24.147.405 Examination.

Collateral References

Licenses + 13, 20, 21.

53 C.J.S. Licenses §§ 30, 33, 34.

51 Am. Jur. 2d Licenses and Permits §§ 10, 11, 74, 80, 81, 85.

MCA 37-19-302, MT ST 37-19-302

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
(1) Human remains may not be cremated except in a licensed crematory.

(2) Human remains may not be cremated within 24 hours after the time of death.

(3) A body may not be cremated with a pacemaker or other potentially hazardous implant, as defined by the board, including any toxic or explosive-type sealed implants, in place. The authorizing agent is responsible for disclosing the existence of any pacemakers or other hazardous implants.

(4) A crematory shall hold human remains, prior to their cremation, under the following conditions:

(a) In the event the crematory is unable to perform cremation upon receipt of the human remains, it shall place the human remains in a holding facility.

(b) If the human remains are not embalmed, they may not be held longer than 48 hours after the time of death outside of a refrigerated facility.

(5) Human remains delivered to a crematory may not be removed from the cremation container, and the cremation container must be cremated with the human remains.

(6) Unauthorized persons may not be permitted in the retort area while any human remains are awaiting cremation, being cremated, or being removed from the cremation chamber.

(7) The unauthorized, simultaneous cremation of human remains of more than one person within the same cremation chamber is prohibited unless the crematory has received express written authorization from all appropriate authorizing agents for the human remains to be cremated simultaneously. A written authorization exempts the crematory from liability for commingling of the product of the cremation process provided the authorization is complied with.

(8) The identification of the human remains, as indicated on the cremation container, must be verified by the crematory operator or crematory technician immediately prior to the cremation container being placed within the cremation chamber. The identification must be removed from the cremation container and be placed near the cremation chamber control panel where it must remain until the cremation process is complete.

(9) Upon completion of the cremation process, all recoverable residue must be removed from the cremation chamber. All residue of the cremation process must be separated from material other than bone fragments, which must be processed so as to reduce the bone fragments to unidentifiable particles.

(10) Cremated remains, with proper identification, must be packed and placed in a temporary container or urn ordered by the authorizing agent.

(11) If the cremated remains will not fit within the dimensions of the temporary container or urn, the remainder of the cremated remains must be returned to the authorizing agent in a separate container.

(12) If the cremated remains are to be shipped, the temporary container or designated receptacle ordered by the authorizing agent must be packed securely in a suitable, sturdy, pressure resistant, and properly sealed container.

(13) Cremated remains may be shipped only by a method that has an internal tracing system available and that provides a receipt signed by the person accepting delivery.

History: En. Sec. 7, Ch. 38, L. 1993.
37-19-706. Disposition of cremated remains

(1) The person arranging the cremation shall require the authorizing agent to provide a signed statement that specifies the ultimate disposition of the cremated remains, if known.

(2) The authorizing agent is responsible for specifying the disposition of the cremated remains. If, after a period of 90 days from the date of cremation, the authorizing agent has not specified the ultimate disposition or claimed the cremated remains, the crematory or person in possession of the cremated remains is responsible for disposition of the cremated remains and may then dispose of the cremated remains in any manner permitted by law. A record of the disposition must be made and kept by the crematory operator. This subsection applies to all cremated remains in the possession of a crematory or other party.

(3) Except with the express written consent of the authorizing agent, a person may not:

(a) dispose of or scatter cremated remains in a manner or in a location that commingles the cremated remains with those of another person. The provisions of this subsection (3) do not apply to the scattering of cremated remains from individual containers over public waterways or by air or to the scattering of cremated remains in an area located in a dedicated cemetery and used exclusively for that purpose.

(b) place cremated remains of more than one person in the same closed container.

(4) Cremated remains must be delivered to the individual specified by the authorizing agent on the cremation authorization form.

(5) A representative of the crematory and the individual receiving the cremated remains shall sign a receipt indicating the name of the deceased and the date, time, and place of the delivery. The crematory shall retain a copy of the receipt, and the original must be given to the authorizing agent. After this delivery, the cremated remains may be transported, in this state, without a permit and disposed of in accordance with this chapter.

History: En. Sec. 8, Ch. 38, L. 1993.
37-19-904. Priority of rights of disposition

(1) A person who is 18 years of age or older and of sound mind wishing to authorize another person to control the disposition of the person's remains may execute an affidavit or a written instrument before a notary public in substantially the following form:

"State of Montana     ] ss
County of ..........  ]

I, ........... [person designating another person to control the disposition of the person's remains] do hereby designate ........... [person who is provided with the right to control the disposition] with the right to control the disposition of my remains upon my death. I ........... have or ........... have not attached specific directions concerning the disposition of my remains with which the designee shall substantially comply, provided the directions are lawful and there are sufficient resources in my estate to carry out the directions. Subscribed and sworn to before me this .......... day of the month of .......... of the year .........."

(2) Except as provided in 37-19-903, 37-19-907 and subsection (1) of this section, the right to control the disposition of the remains of a deceased person, including the location, manner, and conditions of the disposition and arrangements for funeral goods and services, vests in the following persons in the order named if the named person is 18 years of age or older and is of sound mind:

(a) a person designated by the decedent as the person with the right to control the decedent's disposition in an affidavit or written instrument executed in accordance with subsection (1);

(b) the surviving spouse;

(c) the sole surviving child of the decedent or, if there is more than one child of the decedent, the majority of the surviving children. However, less than one-half of the surviving children may be vested with the rights and duties provided in this section if those surviving children have used reasonable efforts to notify all other surviving children of their instructions and they are not aware of opposition to their instructions on the part of more than one-half of all surviving children.

(d) the surviving parent or parents of the decedent. If one of the surviving parents is absent, the remaining parent may be vested with the rights and duties provided in this section if that parent's reasonable efforts have been unsuccessful in locating the absent surviving parent.

(e) the surviving sibling of the decedent or, if there is more than one sibling of the decedent, the majority of the surviving siblings. However, less than one-half of the surviving siblings may be vested with the rights and duties provided in this section if those siblings have used reasonable efforts to notify all other surviving siblings of their instructions and they are not aware of any opposition to their instructions on the part of more than one-half of all surviving siblings.

(f) the surviving grandparent of the decedent or, if there is more than one surviving grandparent, the majority of the grandparents. However, less than one-half of the surviving grandparents may be vested with the rights and duties provided in this section if those grandparents have used reasonable efforts to notify all other surviving grandparents of their instructions and are not aware of any opposition to their instructions on the part of more than one-half of all surviving grandparents.

(g) the guardian of the decedent at the time of the decedent's death, if a guardian had been appointed;

(h) the personal representative of the estate of the decedent;

(i) the person in classes of the next degree of kinship, in descending order, under the laws of descent and distribution to inherit the estate of the decedent. If there is more than one person of the same degree, any person of that degree may exercise the right of disposition.

(j) if the disposition of the remains of the decedent is
the responsibility of the state or a local government, the public officer, administrator, or employee responsible for arranging the disposition of the decedent's remains; and

(k) in the absence of any person provided for in subsections (2)(a) through (2)(j), any other person, including the mortician with custody of the remains, who is willing to assume the responsibility to act and arrange the disposition of the decedent's remains after attesting in writing that a good faith effort has been made to contact the individuals provided for in subsections (2)(a) through (2)(j).

MONTANA CODE ANNOTATED
TITLE 40. FAMILY LAW
CHAPTER 6. PARENT AND CHILD
PART 4. MONTANA SAFE HAVEN NEWBORN
PROTECTION ACT

40-6-402. Definitions

As used in this part, the following definitions apply:

(1) "Child-placing agency" means an agency licensed under Title 52, chapter 8, part 1.

(2) "Court" means a court of record in a competent jurisdiction and, in Montana, means a district court or a tribal court.

(3) "Department" means the department of public health and human services provided for in 2-15-2201.

(4) "Emergency services provider" means:
(a) a uniformed or otherwise identifiable employee of a fire department, hospital, or law enforcement agency when the individual is on duty inside the premises of the fire department, hospital, or law enforcement agency; or
(b) any law enforcement officer, as defined in 7-32-201, who is in uniform or is otherwise identifiable.

(5) "Fire department" means a governmental fire agency organized under Title 7, chapter 33.

(6) "Gross negligence" means conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results.

(7) "Guardian ad litem" means a person appointed to represent a newborn under Title 41, chapter 3.

(8) "Hospital" has the meaning provided in 50-5-101.

(9) "Law enforcement agency" means a police department, a sheriff's office, a detention center as defined in 7-32-2241, or a correctional institution as defined in 45-2-101.

(10) "Newborn" means an infant who a physician reasonably believes to be no more than 30 days old.

(11) "Surrender" means to leave a newborn with an emergency services provider without expressing an intent to return for the newborn.


HISTORICAL AND STATUTORY NOTES
Laws 2007, ch. 449, § 8, in the definition of fire department provided that it means "governmental fire agency organized" rather than "fire department organized by a city, town, or city-county consolidated local government".

LIBRARY REFERENCES

Adoption k7.3.
Health 256.
Infants 192.
Westlaw Key Number Searches: 17k7.3; 198Hk256; 211k192; 268k189(1); 268k202.
C.J.S. Adoption of Persons §§ 56 to 58, 62.
C.J.S. Hospitals § 18.
C.J.S. Infants §§ 24 to 45, 41 to 42, 46 to 48.
C.J.S. Municipal Corporations §§ 450 to 453, 474 to 476, 492 to 495, 497, 505, 508, 535 to 538, 542, 544 to 546, 554 to 557, 562, 564, 568 to 569.

Current through all 2009 legislation

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MCA 40-6-402, MT ST 40-6-402

END OF DOCUMENT
(1) The court has jurisdiction over a newborn who is surrendered to an emergency services provider as provided in 40-6-405. The court may appoint a guardian ad litem to represent a newborn in proceedings under this part.

(2) Except as provided in 40-6-406, the reporting requirements of 41-3-201 do not apply regarding a newborn who is surrendered to an emergency services provider as provided in 40-6-405.

(3) A hospital and the agents and employees of the hospital are immune in a civil action for damages for an act or omission in accepting or transferring a newborn under this part, except for an act or omission constituting gross negligence or willful or wanton misconduct.

History: En. Sec. 3, Ch. 277, L. 2001.

MONTANA CODE ANNOTATED
TITLE 40. FAMILY LAW
CHAPTER 6. PARENT AND CHILD
PART 4. MONTANA SAFE HAVEN NEWBORN PROTECTION ACT

40-6-405. Surrender of newborn to emergency services provider -- temporary protective custody

(1) If a parent surrenders an infant who may be a newborn to an emergency services provider, the emergency services provider shall comply with the requirements of this section under the assumption that the infant is a newborn. The emergency services provider shall, without a court order, immediately accept the newborn, taking the newborn into temporary protective custody, and shall take action necessary to protect the physical health and safety of the newborn.

(2) The emergency services provider shall make a reasonable effort to do all of the following:

(a) if possible, inform the parent that by surrendering the newborn, the parent is releasing the newborn to the department to be placed for adoption according to law;

(b) if possible, inform the parent that the parent has 60 days to petition the court to regain custody of the newborn;

(c) if possible, ascertain whether the newborn has a tribal affiliation and, if so, ascertain relevant information pertaining to any Indian heritage of the newborn;

(d) provide the parent with written material approved by or produced by the department, which includes but is not limited to all of the following statements:

(i) by surrendering the newborn, the parent is releasing the newborn to the department to be placed for adoption and the department shall initiate court proceedings according to law to place the newborn for adoption, including proceedings to terminate parental rights;

(ii) the parent has 60 days after surrendering the newborn to petition the court to regain custody of the newborn;

(iii) the parent may not receive personal notice of the court proceedings begun by the department;

(iv) information that the parent provides to an emergency services provider will not be made public;

(v) a parent may contact the department for more information and counseling; and


(3) After providing a parent with the information described in subsection (1), if possible, an emergency services provider shall make a reasonable effort to:

(a) encourage the parent to provide any relevant family or medical information, including information regarding any tribal affiliation;

(b) provide the parent with information that the parent may receive counseling or medical attention;

(c) inform the parent that information that the parent provides will not be made public;

(d) ask the parent for the parent's name;

(e) inform the parent that in order to place the newborn for adoption, the state is required to make a reasonable attempt to identify the other parent and to obtain relevant medical family history and then ask the parent to identify the other parent;

(f) inform the parent that the department can provide confidential services to the parent; and

(g) inform the parent that the parent may sign a relinquishment for the newborn to be used at a hearing to terminate parental rights.

History: En. Sec. 5, Ch. 277, L. 2001; amd. Sec. 1, Ch. 102, L. 2005.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

2005 Amendment: Chapter 102 in (2)(d)(v) near middle substituted "department" for "safe delivery
line established under 40-6-415"; in (3)(b) near middle substituted "information" for "the pamphlet produced under 40-6-415 and inform the parent"; and made minor changes in style. Amendment effective March 24, 2005.

The amendment to this section made by sec. 53, Ch. 130, L. 2005, was rendered void by sec. 2, Ch. 102, L. 2005, a coordination section.


MCA 40-6-405, MT ST 40-6-405

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
(1) An emergency services provider that is not a hospital and that takes a newborn into temporary protective custody under 40-6-405 shall transfer the newborn to a hospital. The hospital shall accept a newborn transferred to the hospital by an emergency services provider in compliance with this part and shall take the newborn into temporary protective custody.

(2) A hospital that takes a newborn into temporary protective custody under this part must have the newborn examined by a physician. If a physician who examines the newborn either determines that there is reason to suspect the newborn has experienced abuse or neglect, other than being surrendered to an emergency services provider under 40-6-405, or comes to a reasonable belief that the infant is not a newborn, the physician shall immediately report to the department as required under 41-3-201. If the actual date of birth of the infant is not known, the physician shall determine a birth date based on the physician's examination of the infant.

(3) If a physician is not required to report to the department under subsection (2), the hospital shall, no later than the first business day after taking possession of the newborn, notify the department that the hospital has taken a newborn into temporary protective custody under this part.

History: En. Sec. 6, Ch. 277, L. 2001.
The department shall reimburse a hospital for the actual expenses incurred by the hospital in accepting and caring for a newborn who is surrendered under 40-6-405.

History: En. Sec. 13, Ch. 277, L. 2001.
(1) A criminal investigation may not be initiated solely on the basis of a newborn being surrendered to an emergency services provider under this part in the absence of reasonable suspicion of actual abuse or neglect.

(2) Except when there is intentional infliction of injury to the abandoned infant, a criminal prosecution may not be initiated involving the abandonment of an infant that was not more than 30 days old and was surrendered to an emergency services provider under 40-6-405.


<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

(1) This part does not limit the right of an emancipated minor to consent to the provision of health services or to control access to protected health care information under applicable law.

(2) The consent to the provision of health services and to control access to protected health care information by a health care facility or to the performance of health services by a health professional may be given by a minor who professes or is found to meet any of the following descriptions:

(a) a minor who professes to be or to have been married or to have had a child or graduated from high school;

(b) a minor who professes to be or is found to be separated from the minor's parent, parents, or legal guardian for whatever reason and is providing self-support by whatever means;

(c) a minor who professes or is found to be pregnant or afflicted with any reportable communicable disease, including a sexually transmitted disease, or drug and substance abuse, including alcohol. This self-consent applies only to the prevention, diagnosis, and treatment of those conditions specified in this subsection. The self-consent in the case of pregnancy, a sexually transmitted disease, or drug and substance abuse also obliges the health professional, if the health professional accepts the responsibility for treatment, to counsel the minor or to refer the minor to another health professional for counseling.

(d) a minor who needs emergency care, including transfusions, without which the minor's health will be jeopardized. If emergency care is rendered, the parent, parents, or legal guardian must be informed as soon as practical except under the circumstances mentioned in this subsection (2).

(3) A minor who has had a child may give effective consent to health service for the child.

(4) A minor may give consent for health care for the minor's spouse if the spouse is unable to give consent by reason of physical or mental incapacity.

History: En. Sec. 1, Ch. 189, L. 1969; amd. Sec. 1, Ch. 312, L. 1974; amd. Sec. 23, Ch. 100, L. 1977; R.C.M. 1947, 69-6101; amd. Sec. 14, Ch. 440, L. 1989; amd. Sec. 188, Ch. 42, L. 1997; amd. Sec. 2, Ch. 396, L. 2003.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

2003 Amendment: Chapter 396 inserted (1) providing that this part does not limit the right of an emancipated minor to consent to the provision of health services or to control access to protected health care information; in (2) near beginning of introductory clause after "provision of" substituted "health services and to control access to protected health care information by a health care facility" for "medical or surgical care or services by a hospital or public clinic" and after "performance of" substituted "health services by a health professional" for "medical or surgical care or services by a physician licensed to practice medicine in this state"; in (2)(a) after "Minor who" substituted "professes to be or to have been" for "is or was ever" and at end after "school" deleted "or is emancipated"; in (2)(b) after "minor who" substituted "professes to be or is found to be" for "has been"; and made minor changes in style. Amendment effective April 18, 2003.

1997 Amendment: Chapter 42 in (1)(c), in second full sentence after "sexually transmitted disease", substituted "or drug and substance abuse" for "and drug and substance abuse"; and made minor changes in style. Amendment effective March 12, 1997.

1989 Amendment: In (1)(c), in two places, substituted "sexually transmitted" for "venereal".

Saving Clause: Section 21, Ch. 440, L. 1989, was a saving clause.

Severability: Section 22, Ch. 440, L. 1989, was a severability clause.

Cross-References
When parental authority ceases, 40-6-234.

Emergency medical services, Title 50, ch. 6.

Sexually transmitted diseases, Title 50, ch. 18.

Pregnancy -- serological testing, Title 50, ch. 19, part 1.

Parental Notice of Abortion Act, Title 50, ch. 20, part 2.

Mentally ill -- voluntary admission of minors, 53-21-112.

Alcoholism and drug dependence, Title 53, ch. 24.

Law Review Articles


Collateral References

Health and Environment + 23; Infants + 11, 13.

43 C.J.S. Infants §§ 92, 96, 115.


MCA 41-1-402, MT ST 41-1-402

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 41. MINORS
CHAPTER 1. RIGHTS AND OBLIGATIONS OF MINORS
PART 4. CONSENT FOR HEALTH SERVICES

41-1-403. Release of information by health professional

(1) Except with regard to an emancipated minor, a health professional may inform the parent, custodian, or guardian of a minor in the circumstances enumerated in 41-1-402 of any treatment given or needed when:

(a) in the judgment of the health professional, severe complications are present or anticipated;

(b) major surgery or prolonged hospitalization is needed;

(c) failure to inform the parent, parents, or legal guardian would seriously jeopardize the safety and health of the minor patient, younger siblings, or the public;

(d) informing them would benefit the minor's physical and mental health and family harmony; or

(e) the health professional or health care facility providing treatment desires a third-party commitment to pay for services rendered or to be rendered.

(2) Notification or disclosure to the parent, parents, or legal guardian by the health professional may not constitute libel or slander, a violation of the right of privacy, a violation of the rule of privileged communication, or any other legal basis of liability.

If the minor is found not to be pregnant or not afflicted with a sexually transmitted disease or not suffering from drug abuse or substance abuse, including alcohol, then information with respect to any appointment, examination, test, or other health procedure may not be given to the parent, parents, or legal guardian, if they have not already been informed as permitted in this part, without the consent of the minor.


NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

2003 Amendment: Chapter 396 in (1) at beginning of introductory clause substituted "Except with regard to an emancipated minor" for "A treating physician or other" and after "inform the" deleted "spouse"; in (1)(e) at beginning substituted "health professional or health care facility providing treatment" for "hospital"; in (2) near beginning of first sentence after "disclosure to the" deleted "spouse"; and made minor changes in style. Amendment effective April 18, 2003.

1989 Amendment: In (2) substituted "a sexually transmitted" for "venereal".

Saving Clause: Section 21, Ch. 440, L. 1989, was a saving clause.

Severability: Section 22, Ch. 440, L. 1989, was a severability clause.

Cross-References

Privileges, Art. V, M.R.Ev. (see Title 26, ch. 10).
Libel and slander, Title 27, ch. 1, part 8.
Criminal defamation, 45-8-212.
Confidentiality of health care information, Title 50, ch. 16, part 5.
Uniform Health Care Information Act, Title 50, ch. 16, part 5.

Collateral References

Physicians and Surgeons + 12.
70 C.J.S. Physicians and Surgeons § 58.

Validity, construction, and application of state statute requiring doctor or other person to report child abuse. 73 ALR 4th 782.

Pretrial testimony or disclosure on discovery by party to personal injury action as to nature of injuries or treatment as waiver of physician-patient privilege. 25 ALR 3d 1401.
Commencing action involving physical condition of plaintiff or decedent as waiving physician-patient privilege as to discovery proceedings. 21 ALR 3d 912.

Disclosure: physician's tort liability, apart from defamation, for unauthorized disclosure of confidential information about plaintiff. 20 ALR 3d 1109, superseded by 48 ALR 4th 668.

Applicability in criminal proceedings of privilege as to communications between physician and patient. 7 ALR 3d 1458.

Waiver of privilege as regards one physician as a waiver as to other physicians. 5 ALR 3d 1244.

Nurse or attendant, privilege of communications by or to. 47 ALR 2d 742.
Consent of the minor shall not be subject to later disaffirmance or revocation because of minority. The spouse, parent, parents, or legal guardian of a consenting minor shall not be liable for payment for such service unless the spouse, parent, parents, or legal guardian have expressly agreed to pay for such care. Minors so consenting for such health services shall thereby assume financial responsibility for the cost of said services, except those who are proven unable to pay and who receive the services in public institutions. If the minor is covered by health insurance, payment may be applied for services rendered.

History: En. Sec. 3, Ch. 189, L. 1969; amd. Sec. 3, Ch. 312, L. 1974; R.C.M. 1947, 69-6103.

NOTES, REFERENCES, AND ANNOTATIONS

Cross-References

Purchase of insurance by minors, 33-15-103.

Insurance claims and benefits, Title 33, ch. 15, part 5.

Minor not to disaffirm certain obligations, 41-1-306.
MONTANA CODE ANNOTATED
TITLE 41, MINORS
CHAPTER 1. RIGHTS AND OBLIGATIONS OF MINORS
PART 4. CONSENT FOR HEALTH SERVICES

41-1-405. Emergencies and special situations

(1) A health professional may render or attempt to render emergency service or first aid, medical, surgical, dental, or psychiatric treatment, without compensation, to any injured person or any person regardless of age who is in need of immediate health care when, in good faith, the professional believes that the giving of aid is the only alternative to probable death or serious physical or mental damage.

(2) A health professional may render nonemergency services to minors for conditions that will endanger the health or life of the minor if services would be delayed by obtaining consent from spouse, parent, parents, or legal guardian.

(3) Consent may not be required of a minor who does not possess the mental capacity or who has a physical disability that renders the minor incapable of giving consent and who has no known relatives or legal guardians, if a physician determines that the health service should be given.

(4) Self-consent of minors does not apply to sterilization or abortion, except as provided in Title 50, chapter 20, part 2.

History: En. Sec. 4, Ch. 189, L. 1969; amd. Sec. 4, Ch. 312, L. 1974; R.C.M. 1947, 69-6104; amd. Sec. 11, Ch. 469, L. 1995.

NOTES, REFERENCES, AND ANNOTATIONS

Cross-References

Limits on liability for emergency care rendered at scene of accident or emergency, 27-1-714.

Consent in general, Title 28, ch. 2, part 3.

Exemptions from licensing requirements -- emergencies, 37-3-103.

Abortion, Title 50, ch. 20.

Collateral References


Requisites and conditions of judicial consent to minor's abortion. 23 ALR 4th 1061.

Right of minor to have abortion performed without parental consent. 42 ALR 3d 1406.

MCA 41-1-405, MT ST 41-1-405

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MCA 41-1-406, MT ST 41-1-406

When executed by a minor, the consent to the providing of psychiatric or psychological counseling by a physician or psychologist licensed to practice in this state, under circumstances when the need for the counseling is urgent in the opinion of the physician or psychologist involved because of danger to the life, safety, or property of a minor or of another person or persons and the consent of the spouse, parent, custodian, or guardian of the minor cannot be obtained within a reasonable time to offset the danger to life or safety, is as valid and binding as if the minor had achieved majority. The minor has the same legal capacity to act and the same legal obligations with regard to the giving of consent as a person of full legal age and capacity, and the consent is not subject to disaffirmance by reason of minority. The consent of another person, including but not limited to a spouse, parent, custodian, or guardian, is not necessary in order to authorize the psychiatric or psychological counseling of the minor. However, a parent may not be obligated for the cost of the counseling without the parent's consent.


LIBRARY REFERENCES

Health 911.
Infants 49.
Westlaw Key Number Searches: 198Hk911; 211k49.
C.J.S. Infants §§ 260 to 262.
C.J.S. Physicians, Surgeons, and Other Health Care Providers § 116.
C.J.S. Right to Die §§ 4, 23 to 26, 51, 53.

MCA 41-1-406, MT ST 41-1-406
41-1-407. Immunity and responsibility of psychologist, physician, or health care facility

(1) A physician, surgeon, dentist, or health or mental health care facility may not be compelled against the entity's best judgment to treat a minor on the minor's own consent.

(2) This section may not be construed to relieve any physician, surgeon, dentist, or health or mental health care facility from liability for negligence in the diagnosis and treatment rendered a minor.

(3) In any case arising under the provisions of 41-1-406, the physician or licensed psychologist who provides the psychiatric or psychological counseling services may not incur civil or criminal liability by reason of having provided the counseling services, but the immunity does not apply to any negligent acts or omissions.


LIBRARY REFERENCES

Health § 911.
Infants § 49.
Westlaw Key Number Searches: 198Hk911; 211k49.
C.J.S. Infants §§ 260 to 262.
C.J.S. Physicians, Surgeons, and Other Health Care Providers § 116.
C.J.S. Right to Die §§ 4, 23 to 26, 51, 53.

MCA 41-1-407, MT ST 41-1-407

Current through all 2009 legislation

41-3-201. Reports

(1) When the professionals and officials listed in subsection (2) know or have reasonable cause to suspect, as a result of information they receive in their professional or official capacity, that a child is abused or neglected, they shall report the matter promptly to the department of public health and human services.

(2) Professionals and officials required to report are:

(a) a physician, resident, intern, or member of a hospital's staff engaged in the admission, examination, care, or treatment of persons;

(b) a nurse, osteopath, chiropractor, podiatrist, medical examiner, coroner, dentist, optometrist, or any other health or mental health professional;

(c) religious healers;

(d) school teachers, other school officials, and employees who work during regular school hours;

(e) a social worker, operator or employee of any registered or licensed day-care or substitute care facility, staff of a resource and referral grant program organized under 52-2-711, or of a child and adult food care program, or an operator or employee of a child-care facility;

(f) a foster care, residential, or institutional worker;

(g) a peace officer or other law enforcement official;

(h) a member of the clergy, as defined in 15-6-201(2)(a);

(i) a guardian ad litem or a court-appointed advocate who is authorized to investigate a report of alleged abuse or neglect; or

(j) an employee of an entity that contracts with the department to provide direct services to children.

(3) A professional listed in subsection (2)(a) or (2)(b) involved in the delivery or care of an infant shall report to the department any infant known to the professional to be affected by a dangerous drug, as defined in 50-32-101.

(4) Any person may make a report under this section if the person knows or has reasonable cause to suspect that a child is abused or neglected.

(5)(a) Except as provided in subsection (5)(b) or (5)(c), a person listed in subsection (2) may not refuse to make a report as required in this section on the grounds of a physician-patient or similar privilege.

(b) A member of the clergy or a priest is not required to make a report under this section if:

(i) the knowledge or suspicion of the abuse or neglect came from a statement or confession made to the member of the clergy or the priest in that person's capacity as a member of the clergy or as a priest;

(ii) the statement was intended to be a part of a confidential communication between the member of the clergy or the priest and a member of the church or congregation; and

(iii) the person who made the statement or confession does not consent to the disclosure by the member of the clergy or the priest.

(c) A member of the clergy or a priest is not required to make a report under this section if the communication is required to be confidential by canon law, church doctrine, or established church practice.

(6) The reports referred to under this section must contain:

(a) the names and addresses of the child and the
child's parents or other persons responsible for the child's care;

(b) to the extent known, the child's age and the nature and extent of the child's injuries, including any evidence of previous injuries;

(c) any other information that the maker of the report believes might be helpful in establishing the cause of the injuries or showing the willful neglect and the identity of person or persons responsible for the injury or neglect; and

(d) the facts that led the person reporting to believe that the child has suffered injury or injuries or willful neglect, within the meaning of this chapter.


CROSS REFERENCES

Health care information, confidentiality, see § 50-16-603.

ADMINISTRATIVE CODE REFERENCES

Child abuse or neglect and serious incidents, see MT ADC 37.98.319.

Child placing agency: reports, see MT ADC 37.93.715.

Day care facilities: negative licensing action, see MT ADC 37.95.176.

Incident reporting and handling, policy, see MT ADC 37.34.1501.

Incident reporting and handling, see MT ADC 37.34.1506.

License revocation and denial, see MT ADC 20.9.605.

Youth care facility: license revocation and denial, see MT ADC 37.97.115.

Youth care facility: reports, see MT ADC 37.97.130.

Youth foster homes: negative licensing action, see MT ADC 37.51.216.

Youth foster homes: reports of suspected child abuse or neglect, see MT ADC 37.51.607.

LAW REVIEW AND JOURNAL

COMMENTARIES

The child victim as a witness in sexual abuse cases.
Mike McGrath and Carolyn Clemens, 46 Mont. L. Rev. 229 (1985).

LIBRARY REFERENCES

Infants k13.5.
Westlaw Key Number Search: 211k13.5.
C.J.S. Infants §§ 116 to 117.

NOTES OF DECISIONS

In general 1
Compelling accused to criminate himself 4
Immunity 3
Jury instructions 5
Reasonable cause 2

1. In general

There are no "local affiliates" of the Department of Public Health and Human Services. As a result, § 41-3-201(1) should be read to require the reporting of child abuse or neglect to the Department, a requirement which is clearly satisfied by the reporting of child abuse or neglect to the Centralized Intake Bureau. 50 Mont. Op.Att'y Gen. No. 4 (Feb. 26, 2004) 2004 WL 384462.
2. Reasonable cause
Under statute creating duty to report child abuse cases to county attorney, requirement of "reasonable cause" to suspect abuse or neglect only applies to police officers, not other professionals or officials. MCA 41-3-201. Newville v. State, Dept. of Family Services, 1994, 267 Mont. 237, 883 P.2d 793, rehearing denied. Infants Є13.5(1)

Licensed clinical social worker with an independent practice was subject to mandatory child abuse reporting requirement if she had reasonable cause to suspect that a child known to her in her professional capacity was abused or neglected. MCA 41-3-201(1, 2). Gross v. Myers, 1987, 229 Mont. 509, 748 P.2d 459, 73 A.L.R.4th 771. Infants Є13.5(1)

Licensed clinical social worker had reasonable cause to suspect that grandchildren might be subject of abuse, and thus was subject to child abuse reporting mandate of statute, where member of therapy group run by social worker told group about incidents of sexual abuse which occurred between her husband and her daughters approximately 16 years earlier. MCA 41-3-201(1). Gross v. Myers, 1987, 229 Mont. 509, 748 P.2d 459, 73 A.L.R.4th 771. Infants Є13.5(1)

3. Immunity

Statute providing immunity to persons required to report and investigate child abuse does not apply to Department of Family Services in its role of licensing and training foster parents, but rather was intended to protect persons such as teachers, doctors and psychologists who are required to report suspected abuse. MCA 41-3-201, 41-3-202, 41-3-203. Newville v. State, Dept. of Family Services, 1994, 267 Mont. 237, 883 P.2d 793, rehearing denied. Infants Є13.5(2); States Є112.2(1)

4. Compelling accused to criminate himself

Defendant's successful participation in sexual abuse treatment program triggered real danger of self-incrimination sufficient to permit him to invoke his Fifth Amendment right against self incrimination, where program required participants to provide sexual history autobiography and to submit to polygraph examination, and state law would require program counselor to report participants' sex crimes against minors to authorities. U.S.C.A.Const.Amend. 5; MCA 41-3-201. U.S. v. Antelope, 2005, 395F.3d 1128. Criminal Law Є393(1)

5. Jury instructions

Department of Family Services' failure to notify county attorney of report it received from police department concerning possible child abuse incident constituted violation of statutory duty to report incident, and thus trial court erred in refusing to given offered jury instruction relating to department's statutory duty. MCA 41-3-201. Newville v. State, Dept. of Family Services, 1994, 267 Mont. 237, 883 P.2d 793, rehearing denied. Infants Є13.5(1), 17

(1) (a) In a case in which it appears that a child is abused or neglected or is in danger of being abused or neglected, the county attorney, the attorney general, or an attorney hired by the county may file a petition for immediate protection and emergency protective services. In implementing the policy of this section, the child's health and safety are of paramount concern.

(b) A petition for immediate protection and emergency protective services must state the specific authority requested and the facts establishing probable cause that a child is abused or neglected or is in danger of being abused or neglected.

(c) The petition for immediate protection and emergency protective services must be supported by an affidavit signed by a representative of the department stating in detail the facts upon which the request is based. The petition or affidavit of the department must contain information regarding statements, if any, made by the parents detailing the facts of the case. The parents, if available in person or by electronic means, must be given an opportunity to present evidence to the court before the court rules on the petition.

(d) The petition for immediate protection and emergency protective services must include a notice advising the parents, parent, guardian, or other person having physical custody of the youth that the parents, parent, guardian, or other person may have a support person present during any in-person meeting with a social worker concerning emergency protective services. Reasonable accommodation must be made in scheduling an in-person meeting with the social worker.

(2) The person filing the petition for immediate protection and emergency protective services has the burden of presenting evidence establishing probable cause for the issuance of an order for immediate protection of the child, except as provided by the federal Indian Child Welfare Act, if applicable. The court shall consider the parents' statements, if any, included with the petition and any accompanying affidavit or report to the court. If the court finds probable cause, the court may issue an order granting the following forms of relief, which do not constitute a court-ordered treatment plan under 41-3-443:

   (a) the right of entry by a peace officer or department worker;

   (b) the right to place the child in temporary medical or out-of-home care, including but not limited to care provided by a noncustodial parent, kinship or foster family, group home, or institution;

   (c) a requirement that the parents, guardian, or other person having physical or legal custody furnish information that the court may designate and obtain evaluations that may be necessary to determine whether a child is a youth in need of care;

   (d) a requirement that the perpetrator of the alleged child abuse or neglect be removed from the home to allow the child to remain in the home;

   (e) a requirement that the parent provide the department with the name and address of the other parent, if known, unless parental rights to the child have been terminated;

   (f) a requirement that the parent provide the department with the names and addresses of extended family members who may be considered as placement options for the child who is the subject of the proceeding; and

   (g) any other temporary disposition that may be required in the best interests of the child that does not require an expenditure of money by the department unless the court finds after notice and a hearing that the expenditure is reasonable and that resources are available for payment. The department is the payor of last resort after all family, insurance, and other resources have been examined.

(3) An order for removal of a child from the home must include a finding that continued residence of the child with the parent is contrary to the welfare of the child or that an out-of-home placement is in the best interests of the child.

(4) The order for immediate protection of the
child must require the person served to comply immediately with the terms of the order and to appear before the court issuing the order on the date specified for a show cause hearing. Upon a failure to comply or show cause, the court may hold the person in contempt or place temporary physical custody of the child with the department until further order.

(5) The petition must be served as provided in 41-3-422.

History: En. 10-1311 by Sec. 7, Ch. 328, L. 1974; amd. Sec. 21, Ch. 100, L. 1977; R.C.M. 1947, 10-1311(1) thru (3); amd. Sec. 3, Ch. 659, L. 1985; amd. Sec. 44, Ch. 609, L. 1987; amd. Sec. 12, Ch. 458, L. 1995; amd. Sec. 169, Ch. 546, L. 1995; amd. Sec. 2, Ch. 501, L. 1997; amd. Sec. 5, Ch. 281, L. 2001; amd. Sec. 8, Ch. 311, L. 2001; Sec. 41-3-402, MCA 1999; redes. 41-3-427 by Sec. 17(2), Ch. 281, L. 2001; amd. Sec. 8, Ch. 504, L. 2003; amd. Sec. 2, Ch. 422, L. 2005.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

2005 Amendment: Chapter 422 inserted (1)(d) requiring notice of right to have support person present during in-person meeting with social worker. Amendment effective October 1, 2005.

2003 Amendment: Chapter 504 in (2)(g) at end of first sentence substituted "the court finds after notice and a hearing that the expenditure is reasonable and that resources are available for payment" for "the department is notified and a court hearing is set in a timely manner on the proposed expenditure". Amendment effective October 1, 2003.

2001 Amendments -- Composite Section: Chapter 281 throughout section after "petition for" substituted "immediate protection and emergency protective services" for "temporary investigative authority and protective services"; in (1)(a) inserted second sentence requiring that the child's health and safety be of paramount concern; in (1)(c) at beginning of third sentence substituted "The parents, if available in person or by electronic means" for "Except as provided in 41-3-403, the parents" and after "opportunity to" substituted "present evidence to the court" for "address the court"; inserted (2) regarding burden of establishing probable cause and forms of relief to be stated in the order; inserted (3) requiring a finding that continued residence of the child with the parent is contrary to the welfare of the child or that an out-of-home placement is in the best interests of the child; inserted (4) providing that the order for immediate protection of the child must require the person served to comply immediately with the terms of the order and to appear before the court for a show cause hearing and allowing the court to hold the person in contempt or place temporary physical custody of the child with the department upon failure to comply or show cause; inserted (5) regarding service of the petition; and made minor changes in style. Amendment effective October 1, 2001.

Chapter 311 in (1)(c) in first sentence substituted "signed by a representative of the department stating in detail" for "signed by the county attorney, the attorney general, or an attorney hired by the county or must be supported by a department report stating in detail" and near beginning of second sentence after "affidavit" deleted reference to a report; and made minor changes in style. Amendment effective October 1, 2003.

Saving Clause: Section 19, Ch. 281, L. 2001, was a saving clause.

1997 Amendment: Chapter 501 in (3) inserted second and third sentences concerning content of petition, affidavit, or report and opportunity for parents to address court; and made minor changes in style. Amendment effective May 2, 1997.

1995 Amendments: Chapter 458 in (1) and (3), after "by the county", deleted "welfare department or office of human services"; in (3) inserted "must be supported by" and after "department" deleted "of family services"; and made minor changes in style. Amendment effective April 14, 1995.

Chapter 546 in (3) substituted "department of public health and human services" for "department of family services"; and made minor changes in style. Amendment effective July 1, 1995.

Saving Clause: Section 571, Ch. 546, L. 1995, was a saving clause.

1987 Amendment: In middle of (3) changed provision that affidavit be signed by a county welfare department attorney or office of human services attorney to allow signing by an attorney hired by the county welfare department or office of human services.
services and near end substituted "department of family services" for "department of social and rehabilitation services".

1985 Amendment: In (1) near middle after "county attorney" inserted "or an attorney hired by the county welfare department or office of human services"; and in (3) near middle after "county attorney", inserted "attorney general, county welfare department attorney, or office of human services attorney".

Cross-References


Affidavits, Title 26, ch. 1, part 10.

Action on reporting, 41-3-202.

Case Notes

Failure to Adjudicate Child as Youth in Need of Care -- Termination of Parental Rights Improper: A mother was arrested for a parole violation, and the state filed a petition to investigate whether her children were abused or neglected. The District Court granted the petition on a preliminary basis, and the children were placed in a foster home. The mother was released on bond but failed to appear for a show cause hearing. The state's petition was then granted, and the court found that it was in the children's best interests to be removed from the home. The mother was later arrested again, released the following day, and left for Florida, leaving the children behind. She was arrested in Florida about 3 months later, and while incarcerated there, Montana filed for approval of a treatment plan. The treatment plan was faxed to the mother, but she refused to sign it. The plan was approved without her signature. A district citizen review board then recommended that the mother's parental rights be terminated based on the mother's criminal history, the social history of the case, and the children's need for permanence. The District Court terminated the mother's parental rights for failing to comply with the treatment plan, and the mother appealed. The Supreme Court held that termination of parental rights was in error because the children had never been adjudicated as youths in need of care through an adjudicatory hearing, as required by this section. A stipulation by the mother to let the court give temporary custody of the children to the state did not constitute a stipulation or an adjudication that the children were youths in need of care. In re T.C. & W.C., 2001 MT 264, 307 M 244, 37 P3d 70 (2001).

Substantial Risk of Harm to Child -- Parental Rights Terminated Despite Lack of Evidence of Abuse or Neglect: A girl was born to a mother who was later divorced and remarried. When the girl was 15, she had sexual intercourse with her stepfather and conceived a baby. The state petitioned for temporary investigative authority (TIA) and emergency protective services (see 2001 amendment--now "immediate protection and emergency protective services") over both the girl and her baby, pursuant to 41-3-402 (renumbered 41-3-427). The mother then agreed to divorce the stepfather so that he could marry the girl. The petition regarding the girl was dismissed because she was married and was no longer subject to the mother's parental control. At the show cause hearing on the petition regarding protection of the baby, a state social worker testified that, although there was no indication of actual abuse or neglect of the baby, there was concern for the baby's safety should the baby be placed in the home with the girl and stepfather. The state ultimately petitioned to terminate the girl's parental rights to the baby. The District Court determined that the baby was a youth in need of care and terminated the girl's parental rights. The girl appealed on grounds that the court's determination that the baby was a youth in need of care was erroneous, absent any evidence of abuse, neglect, or abandonment, and that the petition for TIA was insufficient on its face because it contained no allegations that the baby was abused or neglected. However, the definition of abuse or neglect in 41-3-102 includes either actual harm or the substantial risk of harm. Thus, the report required by this section need set forth in detail only facts supporting the petition's request for TIA based on the assertion that a child is abused or neglected or is in danger of being abused or neglected. The social worker's testimony was considered sufficient to support a finding that there was substantial risk of harm to the baby if returned to the girl's custody; therefore, the District Court's determination that the baby was a youth in need of care was correct. The court's finding that under the circumstances, the baby had little hope of a normal emotional, moral, and psychological development with his parents was also supported by substantial evidence and was not clearly erroneous, based on the social worker's testimony that the girl's relationship with the stepfather was unhealthy, that the family unit exhibited extremely poor boundaries, and that the girl had obvious psychological damage from being sexually abused by her father and would, without successful treatment, be unable to set appropriate boundaries for the baby.
or be able to understand the risk of harm that her relationship with the stepfather posed to the baby. The Supreme Court affirmed. In re D.T.H., 2001 MT 138, 305 M 502, 29 P3d 1003 (2001).

**Stipulation Not Considered Sufficient Adjudication of Youth in Need of Care -- Lack of Jurisdictional Prerequisite to Terminate Parental Rights:** The mother entered into a stipulation with the state that her children were youths in need of care only upon several conditions: (1) her parental rights would remain intact; (2) the children would reside with their grandmother; (3) the Casey Family Program would manage the children's cases; (4) the mother would always have contact with the children even if the program was required to intervene between the mother and grandmother; and (5) at an appropriate time when the mother was ready, the program, the Department, and the mother would devise a treatment plan that would be completed by the mother in order to regain custody of the children. At a subsequent hearing, the Department proposed a permanency plan that involved removing the children from their grandmother. The mother contended that the proposal amounted to a failure to abide by the conditions of the stipulation, thereby voiding the conditional stipulation that the children were youths in need of care and precluding the District Court's authority to terminate her parental rights. The Supreme Court agreed. Although a stipulation may be an acceptable alternative to an adjudicatory hearing in many circumstances, the fundamental nature of the rights of a parent requires that the process by which a stipulation is drafted and signed needs to be closely scrutinized. In this case, the stipulation was drafted by the County Attorney and signed by the mother without the benefit of legal counsel and essentially allowed the court to determine that the youths were in need of care without a finding that they were abused or neglected and without a hearing as required by 41-3-402 (renumbered 41-3-427). The mother had conflicting feelings about the removal of the children from their grandmother's care and relied on her understanding from the stipulation that the Department would not remove the children or terminate her parental rights, so she did not complete her treatment plan. Only a few days after the initial hearing, she promptly began work toward completion of the treatment plan and had made significant progress, particularly considering the unexpected death of her mother, by the time of the next hearing. Despite the change in circumstances resulting from the death, the Department did not grant the mother any additional time to complete the treatment plan, nor did the Department offer any evidence that the mother had abused or neglected the children. Under the unique facts of this case, the Supreme Court held that the District Court incorrectly found that the stipulation sufficed as an adjudication that the children were youths in need of care. Without that adjudication, the District Court lacked the jurisdictional prerequisite to terminate the mother's parental rights, so the Supreme Court reversed. In re Custody and Parental Rights of M.W. & C.S., 2001 MT 78, 305 M 80, 23 P3d 206 (2001).

**Source of Children's PTSD Not Traceable to Father -- No Abuse of Discretion by Court That Held Children Not Suffering From Abuse and Neglect Caused by Father -- Temporary Investigative Authority (Now "Immediate Protection and Emergency Protective Services") and Temporary Legal Custody Properly Terminated:** John, who pleaded guilty to negligent homicide in the death of his psychotic wife, Nancy, petitioned the District Court for the termination of temporary investigative authority (see 2001 amendment--now "immediate protection and emergency protective services") and temporary legal custody of the Department of Public Health and Human Services, and the petition was granted. The Supreme Court held that the Department's authority was properly terminated because the District Court could not and did not find that the posttraumatic stress disorder (PTSD) suffered by John's children was caused by their father's behavior. The expert testimony given at trial showed that the children's PTSD could have been caused by living with their psychotic mother and not by their father's killing of their mother and his subsequent attempt to cover up the murder. The Supreme Court held that the District Court properly found that the children were not abused or neglected by their father and that the District Court therefore did not abuse its discretion when it granted John's petition and terminated the Department's authority. In re Inquiry Into J.L. & D.L., 2000 MT 289, 302 M 254, 14 P3d 473, 57 St. Rep. 1219 (2000).

**Petition Need Not Allege Abuse or Neglect -- Facts Establishing Probable Cause Sufficient to Issue Order for Protective Services:** A petition for temporary investigative authority (TIA) and protective services (see 2001 amendment--now "immediate protection and emergency protective services") must state the authority requested and facts establishing probable cause that the youth is abused or neglected or in danger of being so and must be accompanied by an affidavit or Department report stating in detail the facts on which the request is made.

based. There is no statutory requirement that the petition contain an allegation of abuse or neglect or the evidence that the Department would present in support of its petition. The fact that the mother stipulated to a 90-day TIA, but not to protective services or the removal of the children from the home, believing that she would retain custody of the children during the 90-day period, did not preclude the District Court from ordering removal of the children from the home. The best interests of the child is paramount and takes precedence over parental rights in abuse and neglect proceedings. In re B.P. & A.P., 2000 MT 39, 298 M 287, 995 P2d 982, 57 St. Rep. 179 (2000).

Appeal From Extension of Temporary Investigative Authority (Now "Immediate Protection and Emergency Protective Services") Held Moot -- Permanent Custody Transferred to Father: When A.E.'s mother, Teresa, filed a pro se appeal from the District Court's extension of temporary custody and temporary investigative authority (see 2001 amendment--now "immediate protection and emergency protective services") of the Department of Public Health and Human Services (Department), Teresa's ex-husband, who was the natural father of A.E., sought and received an amendment to the previous dissolution decree by which his marriage to Teresa was dissolved. The amendment transferred permanent custody of A.E. from Teresa to A.E.'s father. Upon the transfer of custody, the Department sought and received dismissal of its petition for extension of temporary custody and to vacate the District Court's order awarding it temporary legal custody for the purposes of the investigation. On appeal of the award of the extension of temporary investigative authority (see 2001 amendment--now "immediate protection and emergency protective services"), the Supreme Court held that the appeal had been rendered moot because the Department no longer had temporary custody of A.E. and because the Department no longer possessed the authority to investigate. For this reason, the Supreme Court dismissed the appeal. In re A.E., 1998 MT 159, 289 M 340, 961 P2d 1265, 55 St. Rep. 638 (1998).

Evidence Sufficient to Warrant Grant of Temporary Investigative Authority (Now "Immediate Protection and Emergency Protective Services"): Evidence of the mother's previous history of psychiatric problems, fires in the family home, one child's extensive absences from school, and the inability of social workers to investigate these problems due to mother's noncooperation constituted sufficient facts to warrant granting of temporary investigative authority (see 2001 amendment--now "immediate protection and emergency protective services"). In re J.W. & J.C., 226 M 491, 736 P2d 960, 44 St. Rep. 843 (1987).

Only Show Cause Hearing Required Upon Filing Petition for Temporary Investigative Authority (Now "Immediate Protection and Emergency Protective Services"): A mother contended that an order granting temporary custody to the state and allowing temporary investigative authority (see 2001 amendment--now "immediate protection and emergency protective services") under 41-3-402 (renumbered 41-3-427) should be vacated for lack of an adjudicatory hearing pursuant to 41-3-404 (renumbered 41-3-437) and a dispositional hearing pursuant to 41-3-406 (renumbered 41-3-438). In denying the motion to vacate, the District Court properly held that a show cause hearing is the only hearing required when a petition for temporary investigative authority (see 2001 amendment--now "immediate protection and emergency protective services") is filed. In re J.W. & J.C., 226 M 491, 736 P2d 960, 44 St. Rep. 843 (1987).


Exclusion of Evidence on Child Abuse Proceeding Concerning Father -- Harmless Error: It was harmless error, in a child custody modification proceeding, for a District Court judge to exclude evidence that a petition for temporary investigative authority (see 2001 amendment--now "immediate protection and emergency protective services"), alleging sexual abuse by the father, had been filed under Title 41, ch. 3, and dismissed for lack of evidence after being heard by the same judge who made the custody modification determination. In re Marriage of Stout, 216 M 342, 701 P2d 729, 42 St. Rep. 856 (1985).

Order for Protection of Youth -- Rules Suspended -- Procedure on Appeal: A petition for temporary investigative authority and protective services (see 2001 amendment--now "immediate protection and emergency protective services") was filed by the prosecutor under 41-3-402 (renumbered 41-3-427). Temporary custody of K.H. was later awarded to county welfare department under 41-3-403 (renumbered 41-3-423). The District Court found
probable cause for state intervention and ordered temporary investigative authority (see 2001 amendment--now "immediate protection and emergency protective services"), custody in the mother, and restrictions on the father's visitation. The parents appealed the order, an appealable order within Rule 1, M.R.App.Civ.P. (now M.R.App.P.), but not an adequate remedy because of the time involved. Relief should properly be pursued through a Writ of Certiorari, Habeas Corpus, or Supervisory Control. The Supreme Court treated the matter as a Writ of Certiorari and denied it on the grounds that the District Court proceedings were in substantial compliance with law and that the petitioners were not prejudiced thereby. In re K.H., 216 M 267, 701 P2d 720, 42 St. Rep. 796 (1985). However, see In re B.P. & A.P., 2000 MT 39, 298 M 287, 995 P2d 982, 57 St. Rep. 179 (2000), in which it was held that because an interlocutory order granting temporary investigative authority and protective services (see 2001 amendment--now "immediate protection and emergency protective services") is not appealable under Rule 1, M.R.App.P. (Title 25, ch. 21).

Prehearing Report -- Petition for Permanent Custody: The Supreme Court avoided deciding whether or not it is proper for a County Attorney to file a prehearing report in support of a petition under 41-3-401 (renumbered 41-3-422) for permanent custody since the only report in the record was filed in support of a temporary investigative authority and protective services (see 2001 amendment--now "immediate protection and emergency protective services") petition under 41-3-402(3) (renumbered 41-3-427(3)). In re Moyer, 173 M 208, 567 P2d 47 (1977).

Attorney General's Opinions

Authority to Prevent Withholding of Treatment:

The Department of Social and Rehabilitation Services (now Department of Public Health and Human Services) has authority to initiate legal proceedings to prevent the withholding of medically indicated treatment for disabled infants with life-threatening conditions under the 1985 amendments to the child abuse, neglect, and dependency statutes. 41 A.G. Op. 85 (1986).

Collateral References

Temporary removal: validity and application of statute allowing endangered child to be temporarily removed from parental custody. 38 ALR 4th 756.
(1) Unless a petition is dismissed or unless otherwise stipulated by the parties pursuant to 41-3-434 or ordered by the court, a dispositional hearing must be held on every petition filed under this chapter within 20 days after an adjudicatory order has been entered under 41-3-437. Exceptions to the time limit may be allowed only in cases involving newly discovered evidence, unavoidable delays, stipulation by the parties pursuant to 41-3-434, and unforeseen personal emergencies.

(2)(a) A dispositional order must be made after a dispositional hearing that is separate from the adjudicatory hearing under 41-3-437. The hearing process must be scheduled and structured so that dispositional issues are specifically addressed apart from adjudicatory issues. Hearsay evidence is admissible at the dispositional hearing.

(b) A dispositional hearing may follow an adjudicatory hearing in a bifurcated manner immediately after the adjudicatory phase of the proceedings if:

(i) all required reports are available and have been received by all parties or their attorneys at least 5 working days in advance of the hearing; and

(ii) the judge has an opportunity to review the reports after the adjudication.

(c) The dispositional hearing may be held prior to the entry of written findings required by 41-3-437.

(3) If a child is found to be a youth in need of care under 41-3-437, the court may enter its judgment, making any of the following dispositions to protect the welfare of the child:

(a) permit the child to remain with the child's custodial parent or guardian, subject to those conditions and limitations the court may prescribe;

(b) order the department to evaluate the noncustodial parent as a possible caretaker.

(c) order the temporary placement of the child with the noncustodial parent, superseding any existing custodial order, and keep the proceeding open pending completion by the custodial parent of any treatment plan ordered pursuant to 41-3-443;

(d) order the placement of the child with the noncustodial parent, superseding any existing custodial order, and dismiss the proceeding with no further obligation on the part of the department to provide services to the parent with whom the child is placed or to work toward reunification of the child with the parent or guardian from whom the child was removed in the initial proceeding;

(e) grant an order of limited emancipation to a child who is 16 years of age or older, as provided in 41-1-503;

(f) transfer temporary legal custody to any of the following:

(i) the department;

(ii) a licensed child-placing agency that is willing and able to assume responsibility for the education, care, and maintenance of the child and that is licensed or otherwise authorized by law to receive and provide care of the child; or

(iii) a nonparent relative or other individual who has been evaluated and recommended by the department or a licensed child-placing agency designated by the court and who is found by the court to be qualified to receive and care for the child;

(g) order a party to the action to do what is necessary to give effect to the final disposition, including undertaking medical and psychological evaluations, treatment, and counseling that does not require an expenditure of money by the department unless the department consents and informs the court that resources are available for payment. The department is the payor of last resort after all family, insurance, and other resources have been examined.

(h) order further care and treatment as the court
considers in the best interests of the child that
does not require an expenditure of money by the
department unless the department consents and
informs the court that resources are available for
the proposed care and treatment. The department
is the payor of last resort after all family,
insurance, and other resources have been
examined pursuant to 41-3-446.

(4)(a) If the court awards temporary legal custody
of an abandoned child other than to the department
or to a noncustodial parent, the court shall award
temporary legal custody of the child to a member
of the child's extended family, including adult
siblings, grandparents, great-grandparents, aunts,
and uncles, if:

(i) placement of the abandoned child with the
extended family member is in the best interests
of the child;

(ii) the extended family member requests that
the child be placed with the family member;

(iii) the extended family member is able to
offer continuity of care for the child by
providing permanency or stability in residence,
schooling, and activities outside of the home; and

(iv) the extended family member is found by
the court to be qualified to receive and care for
the child.

(b) If more than one extended family member
satisfies the requirements of subsection (4)(a),
the court may award custody to the extended
family member who can best meet the child's
needs.

(c) If a member of the child's extended family,
including an adult sibling, grandparent, grand-
parent, aunt, or uncle, has requested that
custody be awarded to that family member, the
department shall investigate and determine if
awarding custody to the family member is in the
best interests of the child. The department shall
provide the reasons for any denial to the court. If
the court accepts the department's custody
recommendation, the court shall inform any
denied family member of the reasons for the
denial and include the reasons in the court order if
the family member who is denied temporary legal custody requests
it to be included.

(5) If reasonable efforts have been made to prevent
removal of a child from the home or to return a
child to the child's home but continuation of the
efforts is determined by the court to be inconsistent
with permanency for the child, the department shall
make reasonable efforts to place the child in a
timely manner in accordance with a permanent
plan and to complete whatever steps are necessary
to finalize the permanent placement of the child.

(6) If the court finds that reasonable efforts are not
necessary pursuant to 41-3-442(1) or subsection (5)
of this section, a permanency hearing must be held
within 30 days of that determination and
reasonable efforts must be made to place the child
in a timely manner in accordance with the
permanency plan and to complete whatever steps
are necessary to finalize the permanent placement
of the child.

(7) If the time limitations of this section are not
met, the court shall review the reasons for the
failure and order an appropriate remedy that
considers the best interests of the child.

Enacted 10-1314 by Laws 1974, ch. 328, § 10;
Revised Code of Montana 1947, 10-1314; amended
by Laws 1979, ch. 567, § 7; amended by Laws 1981,
ch. 575, § 170; amended by Laws 1983, ch. 564, § 3;
amended by Laws 1985, ch. 659, § 6; amended by
Laws 1987, ch. 609, § 11; amended by Laws 1991,
ch. 696, § 2; amended by Laws 1993, ch. 362, § 2;
amended by Laws 1995, ch. 458, § 15; amended by
Laws 1995, ch. 546, § 170; amended by Laws 1997,
ch. 516, § 9; amended by Laws 1999, ch. 428, § 2;
amended by Laws 1999, ch. 566, § 11; amended by
281, §§ 10,18(3); amended by Laws 2001, ch. 311, §
11; MCA 1999, § 41-3-406; redesignated 41-3-438
by Laws 2001, ch. 281, § 17(2); amended by Laws
2003, ch. 504, § 12; amended by Laws 2005, ch. 178,
§1; amended by Laws 2005, ch. 382, § 5; amended
by Laws 2007, ch. 73, § 1; amended by Laws 2009,
ch. 210, § 5, eff. October 1, 2009; amended by Laws
2009, ch. 179, § 6, eff. October 1, 2009.

ADMINISTRATIVE CODE REFERENCES

Groups covered, AFDC--related
institutionalized individuals, see MT ADC
37.82.1305.

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Youth in need of care 5

1. In general

Transfer of legal custody of abused or neglected youth to relative or other qualified individual pursuant to dispositional hearing is improper unless other procedures required by child abuse, neglect and dependency statutes have been followed. MCA 41-3-101 et seq., 41-3-404, 41-3-406. In re Marriage of Miller, 1992, 251 Mont. 300, 825 P.2d 189. Infants 8222

Dispositional hearing to determine custody of abused child, whom parents stipulated to be youth in need of care, was not required to be dismissed and custody determined in collateral divorce proceedings. MCA 41-3-101(2), 41-3-406. Matter of M. M., 1982, 200 Mont. 244, 650 P.2d 784. Courts 476

At the dispositional stage of a proceeding in youth court, the concern for the youth's welfare and the safety and protection of the community are paramount and are not secondary to the interests of the youth's parents. R.C.M.1947, § 10-1202(2, 3). Matter of Geary, 1977, 172 Mont. 204, 562 P.2d 821. Infants 8222

Where a child is found by a court decree to be dependent and neglected, and its care and custody are awarded to a state agency by the court, the child is as free from parental supervision as when placed in the custody of adoptive parents. State ex rel. Frederick v. District Court of the Fourteenth Judicial Dist., Meagher County, 1946, 119 Mont. 143, 173 P.2d 626. Infants 232

2. Due process

The trial court's failure to adjudicate child as a youth in need of services prior to implementing a court approved treatment plan violated mother's due process rights and warranted reversal of order terminating her parental rights to child; pursuant to statute, an adjudication that a child was a youth in need of care was required before the court could grant temporary custody of the child, develop a treatment plan, or terminate parental rights, and mother never stipulated to a finding that child was a youth in need of care. U.S.C.A. Const.Amend. 14; MCA 41-3-102(23), 41-3-406(1)(c), 41-3-420(1)(2000). In re B.N.Y., 2003, 317 Mont. 291, 77 P.3d 189, on subsequent appeal 331 Mont. 145, 130 P.3d 594. Constitutional Law 4402; Infants 155, 210, 252

Due process is violated if authors of reports relied upon by trial court at hearing to transfer custody of child from parents are not required to testify and be subject to cross-examination. U.S.C.A. Const.Amend. 14, Matter of M.L.H., 1986, 220 Mont. 288, 715 P.2d 32. Constitutional Law 4003

A judge violates due process requirements if he bases his child custody order on statements in a welfare department report without requiring authors of report to testify at hearing and be subject to cross-examination. Matter of Mover, 1977, 173 Mont. 208, 567 P.2d 47. Constitutional Law 4402; Infants 173.1

3. Right to trial by jury

Statute providing that there is no right to jury trial at
parental termination proceeding applies to
adjudicatory hearing where it is determined whether
child or children are in need of care, as well as to the
dispositional hearing, where the parental rights may
actually be terminated, if children have been

4. Deprivation, neglect, or abuse

Once a youth is found to be abused, neglected, or
dependent, custody of that youth can be transferred to
the State. MCA 41-3-404, Matter of A.H., 1989, 236
Mont. 323, 769 P.2d 1245. Infants C 156

Where natural mother of child was provided with
education in nutrition, information, and necessary
training relating to general care of her child by
various agencies and Welfare Department personnel,
best interest of child found to be "neglected" within
meaning of statute permitting legal custody of
neglected children to be transferred to Department of
Social and Rehabilitation Services required
permanent custody to be awarded to Department,
with authority to consent to adoption, as opposed to
granting natural mother permission to enroll herself
and child in single mother program. MCA 41-3-
102(2)(a), 41-3-406(1)(b)(ii), Matter of M. R. L.,
1980, 186 Mont. 468, 608 P.2d 134. Infants C 156

5. Youth in need of care

District court properly found that children were
"youth in need of care," and did not abuse its
discretion in granting Department of Family Services
(DFS) temporary custody of children until age 18,
de spite claim that petition alleged mother had not
complied with treatment plan, and that no treatment
plan was in effect when petition was filed; after
petition was filed, DFS and mother agreed to enter
treatment plan which mother failed to complete by
time of final hearing. MCA 41-3-102(11), Matter of F.H., 1994, 266 Mont. 36, 878 P.2d 890. Infants C 177, 222

Once district court determines that child is "youth in
need of care"--abused, neglected or dependent--it
may grant Department of Family Services (DFS)
temporary custody of that child until age 18. MCA
41-3-102(11), Matter of F.H., 1994, 266 Mont. 36,
878 P.2d 890. Infants C 222

When evidence demonstrates that child is youth in
need of care who is abused, neglected, or dependent,
district court may order that child be placed in
temporary legal custody of Department of Family
Services (DFS) until child reaches majority, if court
determines that such custody is in child's best
interests. MCA 41-3-404, 41-3-406, Matter of T.A.,
1991, 249 Mont. 186, 814 P.2d 994. Infants C 222

6. Parental unfitness or incompetence

Trial court's transfer of long-term custody of minor
to the State was not an abuse of discretion
where mother had been diagnosed as being a manic
depressive in a hypomanic stage, mother consistently
refused to take prescribed medication and exhibited
behavior problems including threatening behavior,
lack of coherence and control, and children exhibited
behavior problems including anxiety, identity
disorders, depression, and possible suicidal
tendencies. MCA 41-3-406, Matter of A.H., 1989,
236 Mont. 323, 769 P.2d 1245. Infants C 158

7. Visitation

In ordering "termination" of parents' custodial rights
and awarding legal custody of children to Department
of Family Services, trial court did not intend to
terminate parents' custodial rights; during hearing
State asserted in its request for permanent custody it
did not envision total termination of parental rights of
either father or mother and recognized necessity of
continued visitation with parents and grandparents,
district court awarded supervised visitation rights to
mother, father and paternal grandparents which was
inconsistent with terminating parental rights, and in
its conclusions of law, trial court cited statute
providing for long-term custody as authority for its
actions. MCA 41-3-406, Matter of B.N., 1990, 245
Mont. 511, 802 P.2d 1244. Infants C 222

Order granting long-term custody of boy to maternal
grandparents was not the equivalent of a termination
of parental rights; although mother's visitation rights
were restricted, she could still visit her child and
could possibly petition for less restricted visitation in
the future. MCA 41-3-404, 41-3-609, In re R.T.L.P.,
1989, 238 Mont. 384, 777 P.2d 892. Infants C 222

8. Treatment plan

Trial court had authority to award custody of abused
and neglected child to county department of public
welfare and to require that child and her parents
follow treatment plan set up by that department in
light of evidence of sexual abuse and other problems


Infants 222

9. Placement to foster or adoptive home

Stipulation by a parent that a child is a youth in need of care empowers the court to transfer legal custody from the parent to the Department of Public Health and Human Services (DPHHS). In re T.C., 2001, 307 Mont. 244, 37 P.3d 70. Infants 226

Award of mother's custodial rights with regard to four minor children to state agency, following a stipulation that minors were youths in need of care, was not abuse of discretion, where mother after moving to Wyoming failed to satisfy treatment plan requirements and lost contact with children, and where court determined that children had improved emotionally during foster placement with aunt and uncle and needed finality of placement for their emotional health. MCA 41-3-404, 41-3-406(1). Matter of Custody of J.H., 1998, 289 Mont. 111, 958 P.2d 1191. Infants 226

Stipulation in a child neglect and dependency proceeding that a child is a youth in need of care empowers a district court, in its discretion, to transfer legal custody of the child from the parents to the Department of Public Health and Human Services. MCA 41-3-404, 41-3-406(1). Matter of Custody of J.H., 1998, 289 Mont. 111, 958 P.2d 1191. Infants 226

District court has authority to take appropriate measures, including transferring legal custody to Department of Public Health and Human Services, to safeguard welfare of child determined to be youth in need of care. MCA 41-3-406. Matter of C.M., 1997, 281 Mont. 183, 932 P.2d 1063. Infants 226

Foster parents were statutorily entitled to seek legal custody of child in proceeding to terminate parental rights of natural parents, and trial court, if it determined that it was in child's best interest, could award permanent legal custody to foster parents, notwithstanding reference by Department of Family Services to statute pursuant to which child may be placed for adoption only with Department, licensed child-placing agency, and child's parents. MCA 40-8-108, 41-3-406(1)(c)(iii). Matter of J.J.G., 1994, 266 Mont. 274, 880 P.2d 808. Infants 226

In order for individual to obtain permanent legal custody of child under statute authorizing court to transfer custody to any qualified individual in order to protect welfare of child, it is not necessary for individual to have authority to consent to adoption or to seek termination of parental rights. MCA 41-3-406. Matter of J.J.G., 1994, 266 Mont. 274, 880 P.2d 808. Infants 226

Under statute authorizing court to transfer legal custody of child to any qualified individual in order to protect welfare of child, possibility that Department of Family Services would not find child's foster parents to be qualified to care for child was irrelevant to court's determination inasmuch as it was court that had authority to determine if individual was qualified to care for child after individual was studied by "a" social service agency designated by court, and court was not obligated to designate Department as agency to evaluate foster parents. MCA 41-3-406. Matter of J.J.G., 1994, 266 Mont. 274, 880 P.2d 808. Infants 226

Fact that foster parents could not "place" child for adoption was irrelevant to question of whether they had right to seek permanent legal custody of child. MCA 40-8-108, 40-8-111(1)(d), 41-3-406. Matter of J.J.G., 1994, 266 Mont. 274, 880 P.2d 808. Infants 226

10. Best interests of children

District court determining custody of youth in need of care is bound to give primary consideration to physical, mental, and emotional conditions and needs of children; best interests of children are paramount and must take precedence over parental rights. MCA 41-3-406. Matter of C.M., 1997, 281 Mont. 183, 932 P.2d 1063. Infants 222

Paramount consideration in court's exercise of discretionary authority to transfer legal custody of child to any qualified individual, including nonrelative, in order to protect welfare of child is best interest of child. MCA 41-3-406. Matter of J.J.G., 1994, 266 Mont. 274, 880 P.2d 808. Child Custody 76; Infants 226

District court did not abuse its discretion in determining that it was in best interests of children to remain in custody of Department of Social and Rehabilitation Services following termination of parental rights, rather than under jurisdiction of Indian tribe. MCA 41-3-406(5), 41-3-609, 41-3-

Under all evidence, including conflicting evidence, and fact that grandmother wished to return with children to place which was only 50 miles from where natural parents were living and fact that grandmother needed to work, trial court's finding that it would be in best interest of children that custody be awarded to the Department of Social and Rehabilitation Services with right to consent to adoption was sustained. MCA 41-3-404, 41-3-406. Matter of M. N., 1982, 199 Mont. 407, 649 P.2d 749. Infants 222

The "best interest of the child" test is used only after a showing of dependency or abuse or neglect of child by natural parent or in custody disputes between parents. R.C.M.1947, §§ 10-1301, 61-105, 61-205. Matter of Guardianship of Doney, 1977, 174 Mont. 282, 570 P.2d 575. Child Custody 76, 77; Infants 222

11. Opportunity to contest adjudication

Mother had a fair opportunity to contest the adjudication of her child as a youth in need of care, where she had two such opportunities, the first of which occurred when she was properly served with notice of the hearing and could have contested the adjudication of her child as a youth in need of care at that time but chose to flee with the child instead, and the second of which occurred when the trial court held a hearing to determine the current status of the child and to make a dispositional ruling after mother returned to the state. Matter of B.L.O., 1984, 213 Mont. 164, 689 P.2d 1246. Infants 198, 203

12. Discretion of court

Statute providing for dispositional hearing for youth found to be abused, neglected or dependent is not mandatory but places discretion in district court whether or not to award custody to relatives. MCA 41-3-406. Matter of M. N., 1982, 199 Mont. 407, 649 P.2d 749. Infants 222

13. Combined hearing

Adjudicatory and dispositional hearings in proceeding to terminate parental rights were properly combined, and father was not entitled to specific notice of such combination. MCA 41-3-607. Matter of R.A.D., 1988, 231 Mont. 143, 753 P.2d 862.

14. Hearing, generally

The trial court was not required to conduct a separate dispositional hearing after it adjudicated children as youths in need of care, where parents stipulated that children were youths in need of care, they each signed treatment plans and began to follow the plans, and they agreed to allow the Department of Public Health and Human Services to have temporary custody of the children. MCA 41-3-434, 41-3-438(1, 2). In re B.B., 2006, 331 Mont. 407, 133 P.3d 215. Infants 203

District Court considering petition to terminate parental rights was required to structure the dispositional issues apart from the adjudicatory issues. MCA 41-3-438(2)(a). In re S.C., 2005, 328 Mont. 476, 121 P.3d 552. Infants 203

15. Discovery and disclosure

Father challenging attempt to have daughter classified as youth in need of care could not compel further discovery from state regarding identification of witness, substance of testimony, and who would be testifying as to details of state's petition, made six days before hearing date; identity of witnesses had been informally known to father for some time, and he could have required additional information directly through interviews. Matter of H.D., 1992, 256 Mont. 70, 844 P.2d 114. Infants 201

Where infant's grandfather was age 73, worked in mornings, and would have been required to furnish babysitter to care for infant, trial court did not abuse its discretion in refusing to order home study of grandparents' home in order to determine their suitability to care for infant son upon determination of abuse, neglect or dependency of such infant. MCA 41-3-406(1). Matter of T. J. D., 1980, 189 Mont. 147, 615 P.2d 212. Infants 201

16. Burden of proof

Where children were dependent and neglected and their necessities of life had been continuously provided at public expense for almost three years, it was not incumbent on welfare department to assume burden of proving every fact relating to natural mother's emotional stability at time of hearing, where she had apparently consented to permanent custody with right of adoption in welfare department, and that
would not be such fraud upon the court as would support setting aside prior judgment awarding state welfare department permanent custody with authority to consent to adoption. R.C.M.1946, § 10-501. In re Bad Yellow Hair, 1973, 162 Mont. 107, 509 P.2d 9. Infants § 172, 230.1

17. Admissibility of evidence

District court properly considered only admissible evidence in reports relied on at hearing to transfer custody of children from parents, where authors of reports testified and were subject to cross-examination and no evidence was presented to rebut presumption that any hearsay within reports themselves was disregarded by district court. Matter of M.L.H., 1986, 220 Mont. 288, 715 P.2d 32. Infants § 210

18. Child witnesses

Child who was five years old at time of alleged sexual abuse and six years old at time of hearing to consider termination of parental rights, and child who was three years old at time of alleged abuse and five years old at time of hearing, were properly determined to be competent to testify, despite father's contention that they were inconsistencies in children's statements during voir dire; trial court ascertained that children knew difference between "good touch" and "bad touch." Matter of R.A.D., 1988, 231 Mont. 143, 753 P.2d 862. Infants § 207

19. Sufficiency of evidence

Substantial evidence supported finding that condition of parent that rendered her unfit was unlikely to change within a reasonable time, as statutory requirement for termination of parental rights; condition was parent's abuse and neglect of her children, and none of the witnesses at the termination hearing testified that parent's condition changed sufficiently to ensure that children would not be subjected to further abuse. MCA 41-3-609(1). In re Custody and Parental Rights of F.M., 2001, 305 Mont. 189, 24 P.3d 208. Infants § 181

Evidence supported determination that child was youth in need of care, and would be removed from custody of father; child had given videotape testimony that she had been sexually abused by her father, which was corroborated by medical testimony, and even if sexual abuse charge was not true, medical testimony showed that child's mental health had been damaged while father was responsible for her. MCA 41-3-102(2, 11). Matter of H.D., 1992, 256 Mont. 70, 844 P.2d 114. Infants § 179

Finding that conduct or condition rendering mother unfit was unlikely to change within a reasonable time, warranting termination of parental rights, was supported by testimony of physician who had diagnosed mother as being a manic depressive in a hypomanic stage that three or four-month period would be a minimum time frame for stabilizing the mother after which it would be necessary to assess her situation and begin a course of treatment, physician's testimony about problems encountered in getting the mother to take medication which could lengthen the stabilization period significantly, and evidence of mother's persistent and perhaps worsening condition including behavior problems exhibited at hearing. MCA 41-3-609. Matter of A.H., 1989, 236 Mont. 323, 769 P.2d 1245. Infants § 181

Adjudicatory order and dispositional order placing children in two separate foster homes was not supported by substantial evidence, because of uncertainty of substance of in-chambers interview of children. Matter of M.L.H., 1986, 220 Mont. 288, 715 P.2d 32. Infants § 177

Before parental rights may be terminated, state must demonstrate by clear and convincing evidence that statutory criteria have been met. MCA 41-3-406, 41-3-607, 41-3-609. Matter of C.A.R., 1984, 214 Mont. 174, 693 P.2d 1214. Infants § 178

Substantial evidence supported finding of continuing potential for abuse of child by mother as basis for depriving her of custody, in view of evidence showing continuing stress in handling parental responsibilities, lack of support system, and family history of abuse, and that mother still exhibited tendency to abuse child after efforts by Department of Social and Rehabilitation Services to help her with her problems for some ten months. MCA 41-3-101(2). Matter of M. M., 1982, 200 Mont. 244, 650 P.2d 784. Infants § 179

District court's conclusion that child was "neglected child" within meaning of statute providing that commission of any act which materially affects normal physical or emotional development of youth...
constitutes neglect, was supported by clear and convincing evidence that child's physical condition deteriorated while in care of natural mother but improved dramatically while in foster care, and by testimony of physician, nurses, and Welfare Department personnel that child was failing to thrive while in care of natural mother; therefore, district court was justified in permanently depriving natural mother of child. MCA 41-3-102(2)(a), 41-3-406(1)(b)(ii). Matter of M. R. L., 1980, 186 Mont. 468, 608 P.2d 134. Infants 210

Where mother had beaten her child with belt or belt buckle inflicting bruises on child's back, shoulder, arm, rib cage, and a welt or bruise behind her left ear, social worker testified that she was aware of four other incidents of child abuse, that child had been placed away from her natural mother in foster care on five separate occasions, and that three of five foster care placements had taken place after acts of abuse had occurred and psychologist testified that potential for further child abuse by natural mother was high and recommended that child not be returned to natural mother, there was substantial credible evidence in the record to justify district court order permanently depriving mother of her child. MCA 41-3-406(1)(b)(i). In re M. A. M., 1979, 183 Mont. 434, 600 P.2d 203. Infants 179

In child custody hearing, testimony of clinical psychologist, school nurse, police officer, and other witnesses produced ample evidence to support judge's finding that children were abused and neglected while in custody of mother, and judgment that it would be in children's best interests to transfer their legal custody to division of public welfare department. R.C.M.1947, §§ 10-1301, 10-1314(1)(b)(i). Matter of Moyer, 1977, 173 Mont. 208, 567 P.2d 47. Infants 179

Evidence that welfare department had assumed responsibility for infant and cared for him for approximately one month after mother left infant at babysitter's and failed to return was sufficient to support district court's decision that infant was "dependent youth," within meaning of statute allowing custody of child to be transferred from parent. R.C.M.1947, §§ 10-1301, 10-1314. Matter of Henderson, 1975, 168 Mont. 329, 542 P.2d 1204. Infants 177

Findings

Before court can award permanent custody of any child to the Department of Social and Rehabilitation Services with a termination of parental rights, it must make certain findings in accordance with statutes. MCA 41-3-406, 41-3-607, 41-3-609. Matter of C.A.R., 1984, 214 Mont. 174, 693 P.2d 1214. Infants 210

District court abused its discretion in awarding permanent custody of child to Division of Child Welfare Services of Department of Social and Rehabilitation Services while failing to find that child was "abused, dependent or neglected" within meaning of statute. R.C.M.1947, § 10-1301. Matter of Fish, 1977, 174 Mont. 201, 569 P.2d 924. Infants 210

Finding of abuse, neglect or dependency is the jurisdictional prerequisite to any court-ordered transfer of child custody, for it is then, and only then, that "best interests of the child" standard has its application in resolution of question of custody. R.C.M.1947, §§ 10-1312, 10-1314. Matter of Fish, 1977, 174 Mont. 201, 569 P.2d 924. Infants 210

Modification of order or placement

Unlike custody awards involving minor children in divorce actions, there is no continuing jurisdiction in dependent and neglected child proceedings to alter or modify a permanent custody award with right of adoption. R.C.M.1947, § 10-5-1. In re Bad Yellow Hair, 1973, 162 Mont. 107, 509 P.2d 9. Infants 230.1

Dismissal

Once mother's children were adjudicated youths in need of care, State had statutory authority to place children in custody of children's father in Maine and to dismiss mother's case with no further obligation by State. MCA 41-3-438(3)(b). In re A.C., 2004, 324 Mont. 58, 101 P.3d 761. Infants 202

Preservation of grounds for review

Father failed to preserve for appellate review claim that failure to bifurcate youth in need of care hearing from dispositional hearing granting Department of Health and Human Services temporary legal custody of child violated father's right to fundamentally fair process, where father failed to raise claim with trial court. MCA 41-3-438(2). In re A.N.W., 2006, 331 Mont. 208, 130 P.3d 619. Infants 243
Even though trial court elicited information from father concerning his prior conviction of felony, it was duty of father's counsel to object, and therefore, father of infant son whose parental rights in such son had been terminated had waived any right to complain of error in admission of such testimony at hearing to determine whether parental rights should be terminated. Rules of Evidence, Rule 103(a)(1). Matter of T. J. D., 1980, 189 Mont. 147, 615 P.2d 212. Infants 243

24. Review

District court's failure initially to structure dispositional issues apart from adjudicatory issues in termination of parental rights action was harmless error, where court, upon discovery of the error, immediately sought to remedy the misstep by scheduling a dispositional hearing to address the dispositional issue separately, and second hearing made initial order to place children in foster care functionally equal to an order of placement pending the dispositional hearing. MCA 41-3-438(2)(a). In re S.C., 2005, 328 Mont. 476, 121 P.3d 552. Infants 253

Failure to grant fourth continuance in proceeding to terminate mother's parental rights, due to mother's mental condition and commitment at state hospital, did not constitute reversible error; psychiatrist indicated that mother was not responding well to treatment and that her court-ordered commitment could be extended, and mother's counsel is unable to indicate when, if at all, mother would be able to attend termination hearing. Matter of R.A.D., 1988, 231 Mont. 143, 753 P.2d 862. Infants 253

District court erred in stating its intention to transfer custody of children from parents to Department of Social and Rehabilitation Services before parties had opportunity to present any evidence at dispositional hearing. Matter of M.L.H., 1986, 220 Mont. 288, 715 P.2d 32. Infants 210

Where all that mother, who had previously abused child, had done on appeal was to argue and quote some testimony that would support award of child's custody to her, such was insufficient to establish abuse of discretion in findings in dispositional hearing for determination of child's custody. MCA 41-3-101(2). Matter of M. M., 1982, 200 Mont. 244, 650 P.2d 784. Infants 251

MCA 41-3-438, MT ST 41-3-438
MONTANA CODE ANNOTATED
TITLE 41. MINORS
CHAPTER 3. CHILD ABUSE AND NEGLECT
PART 4. ABUSE OR NEGLECT PROCEEDINGS
41-3-442. Temporary legal custody

(1) If a child is found to be a youth in need of care under 41-3-437, the court may grant temporary legal custody under 41-3-438 if the court determines by a preponderance of the evidence that:

(a) dismissing the petition would create a substantial risk of harm to the child or would be a detriment to the child's physical or psychological well-being; and

(b) unless there is a finding that reasonable efforts are not required pursuant to 41-3-423, reasonable services have been provided to the parent or guardian to prevent the removal of the child from the home or to make it possible for the child to safely return home.

(2) An order for temporary legal custody may be in effect for no longer than 6 months.

(3) The granting of temporary legal custody to the department allows the department to place a child in care provided by a custodial or noncustodial parent, kinship foster home, youth foster home, youth group home, youth shelter care facility, or institution.

(4) Before the expiration of the order for temporary legal custody, the county attorney, the attorney general, or an attorney hired by the county shall petition for one of the following:

(a) an extension of temporary legal custody, not to exceed 6 months, upon a showing that:

(i) additional time is necessary for the parent or guardian to successfully complete a treatment plan; or

(ii) continuation of temporary legal custody is necessary because of the child's individual circumstances;

(b) continued temporary placement of the child with the noncustodial parent, superseding any existing custodial order; or

(c) termination of the parent-child legal relationship and:

(i) permanent legal custody with the right of adoption;

(ii) permanent placement of the child with the noncustodial parent, superseding any existing custodial order; or

(iii) appointment of a guardian pursuant to 41-3-607;

(d) long-term custody when the child is in a planned permanent living arrangement pursuant to 41-3-445;

(e) appointment of a guardian pursuant to 41-3-444; or

(f) dismissal.

(5) The court may continue an order for temporary legal custody pending a hearing on a petition provided for in subsection (2).

(6) If an extension of temporary legal custody is granted to the department, the court shall state the reasons why the child was not returned home and the conditions upon which the child may be returned home and shall specifically find that an extension is in the child's best interests.

(7) If the time limitations of this section are not met, the court shall review the reasons for the failure and order an appropriate remedy that considers the best interests of the child.

(8) In implementing the policy of this section, the child's health and safety are of paramount concern.

(9) A petition requesting temporary legal custody must be served as provided in 41-3-422.


LIBRARY REFERENCES
Infants 222, 230.
Westlaw Key Number Searches: 211k222; 211k230.
NOTES OF DECISIONS

In general

1. In general

An adjudication that a child is a youth in need of care (YINC) is required for a transfer of temporary legal custody (TLC) and for a termination of parental rights based on YINC status, if none of the other criteria under the termination statute are applicable. In re J.C., 183 P.3d 22, 343 Mont. 30 (2008). Infants

A court may deem a youth in need of care regardless of the parent's care for the child, or even whether actual abuse or neglect occurred. MCA 41-3-437(7)(a), 41-3-442(1). In re D.A., 2003, 315 Mont. 340, 68 P.3d 735. Infants

Trial court's findings of facts were sufficient to allow meaningful appellate review of trial court's findings that minor child was a youth in need of care; the trial court found that county proved its allegation that child was abused, dependent and neglected, the trial court found that the mother's condition prevented her from providing adequate protection to child, and trial court found that dismissing the petition for temporary custody would create a substantial risk of harm to the child. MCA 41-3-437(7)(a), 41-3-442(1). In re D.A., 2003, 315 Mont. 340, 68 P.3d 735. Infants

Current through all 2009 legislation

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MCA 42-2-402, MT ST 42-2-402

West's Montana Code Annotated
Currentness
Title 42. Adoption

Chapter 2, Adoption of Child (Refs & Annos)
Part 4, Voluntary Relinquishment and Consent to Adopt (Refs & Annos)

42-2-402. Voluntary relinquishment--validity

(1) A voluntary relinquishment is not valid unless the parent specifically relinquishes custody of the child to the department, a licensed child-placing agency, or a specifically identified prospective adoptive parent and:

(a) the department or agency to whom the child is being relinquished has agreed in writing to accept custody of the child until the child is adopted; or

(b) the identified prospective adoptive parent has agreed in writing to accept temporary custody and to provide support and care to the child until that person's adoption petition is granted or denied.

(2) A voluntary relinquishment of a parent's rights solely to the child's other parent does not relieve the parent executing the relinquishment of any duty owed to the child or for the child's support.

Enacted by Laws 1997, ch. 480, § 43.

LIBRARY REFERENCES
Adoption § 7.3, 7.5.
Westlaw Key Number Searches: 17k7.3; 17k7.5.
C.J.S. Adoption of Persons §§ 56 to 58, 62, 70 to 73.

NOTES OF DECISIONS

In general 1

1. In general

District court was not precluded from continuing termination of parental rights hearing and involuntarily terminating father's parental rights to child, even though father voluntarily relinquished his parental rights to child during hearing; statute listing the criteria for termination stated that parental relinquishment was one circumstance that the court could consider, and relinquishment was only one of several criteria the court could consider when deciding whether to terminate parental rights. MCA 41-3-609, 42-2-402(1). In re P.S., 2006, 330 Mont. 239, 127 P.3d 451. Infants § 199, 210

Fact that parental release and consent to adopt was contained in one document, contrary to requirements of Uniform Parentage Act, was not fatal. MCA 40-6-124. In re Adoption of BGB, 1979, 183 Mont. 347, 599 P.2d 375. Adoption § 7.5

A parental release allegedly involuntarily executed can be contested without consent of person or agency to whom child has been released. MCA 40-6-124(1, 7). In re Adoption of BGB, 1979, 183 Mont. 347, 599 P.2d 375. Adoption § 7.5

In proceeding to terminate parental rights under Uniform Parentage Act, record was insufficient to support conclusion that parental release had been voluntarily executed by natural mother. MCA 40-6-101 to 40-6-131. In re Adoption of BGB, 1979, 183 Mont. 347, 599 P.2d 375. Infants § 178

MCA 42-2-402, MT ST 42-2-402

Current through all 2009 legislation

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END OF DOCUMENT
42-2-405. Relinquishment by minor parent--separate legal counsel in direct parental placement adoption

(1) A parent who is a minor has the right to relinquish all rights to that minor parent's child and to consent to the child's adoption. The relinquishment is not subject to revocation by reason of minority.

(2) In a direct parental placement adoption, a relinquishment and consent to adopt executed by a parent who is a minor is not valid unless the minor parent has been advised by an attorney who does not represent the prospective adoptive parent. Legal fees charged by the minor parent's attorney are an allowable expense that may be paid by prospective adoptive parents under 42-7-101, subject to the limitations in 42-7-102.

(3) If in the court's discretion it is in the best interest of justice, the court may order the office of state public defender, provided for in 47-1-201, to assign counsel to represent the minor parent.


CROSS REFERENCES

Minors and adults, definitions, see § 41-1-101.

LIBRARY REFERENCES

Adoption k7.3.
Westlaw Key Number Search: 17k7.3.
C.J.S. Adoption of Persons §§ 56 to 58, 62.

NOTES OF DECISIONS

In general

Minor mother's lack of legal representation rendered relinquishment of parental rights and consent to direct parental placement adoption invalid, even though adoptive parents did not provide mother with lawyer because mother led them to believe she was of legal age. MCA 42-2-405(2). In re Adoption of A.L.O., 2006, 331 Mont. 334, 132 P.3d 543.
(1) A parent whose consent to the adoption of a child is required may execute a relinquishment and consent to adoption only after the following criteria have been met:

(a) the child has been born;

(b) not less than 72 hours have elapsed since the birth of the child;

(c) the parent has received counseling in accordance with 42-2-409; and

(d) in a direct parental placement adoption:

(i) the parent has been informed that fees for any required counseling and legal fees are allowable expenses that may be paid by a prospective adoptive parent under 42-7-101, subject to the limitations set in 42-7-102;

(ii) if the parent is a minor, the parent has been represented by separate legal counsel; and

(iii) prior to the execution of the relinquishment, the parent has been provided a copy of the preplacement evaluation prepared pursuant to 42-3-204 pertaining to the prospective adoptive parent.

(2) A guardian may execute a relinquishment and consent to adopt at any time after being authorized by a court.

(3) The department or a licensed child-placing agency may execute a consent for the adoption at any time before or during the hearing on the petition for adoption.

(4) A child whose consent is required may execute a consent at any time before or during the hearing on the petition to adopt.

(5) Except as provided in this section, a relinquishment and consent to adopt must be a separate instrument executed before a notary public.

(6) If the person from whom a relinquishment and consent to adopt is required is a member of the armed services or is in prison, the relinquishment may be executed and acknowledged before any person authorized by law to administer oaths.

Enacted by Laws 1997, ch. 480, § 47.

OFFICIAL COMMENTS

See official comments for this chapter.

CROSS REFERENCES

Uniform Law on Notarial Acts, see § 1-5-601 et seq.

LIBRARY REFERENCES

Adoption C⇒7.3, 7.5.
Westlaw Key Number Searches: 17k7.3; 17k7.5.
C.J.S. Adoption of Persons §§ 56 to 58, 62, 70 to 73.

MCA 42-2-408, MT ST 42-2-408

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END OF DOCUMENT
42-2-412. Content of relinquishment and consent to adopt

(1) A relinquishment and consent to adopt must be in writing and must contain:

(a) the date, place, and time of the execution of relinquishment and consent to adopt;

(b) the name, date of birth, and current mailing address of the individual executing the relinquishment and consent to adopt;

(c) the date of birth and the name of the child to be adopted; and

(d) the name, address, and telephone numbers of the department or agency to which the child is being relinquished or the name, address, and telephone numbers of the prospective adoptive parent with whom the individual executing the relinquishment and consent has placed or intends to place the child for adoption.

(2) A relinquishment and consent to adopt executed by a parent or guardian must state that the parent or guardian executing the document is voluntarily and unequivocally consenting to the:

(a) permanent transfer of legal and physical custody of the child to the department or agency for the purposes of adoption; or

(b) transfer of permanent legal and physical custody to, and the adoption of the child by, a specific identified adoptive parent whom the parent or guardian has selected.

(3) A relinquishment and consent to adopt must state:

(a) that after the document is signed or confirmed in substantial compliance with this section, it is final and, except under a circumstance stated in 42-2-411, may not be revoked or set aside for any reason, including the failure of an adoptive parent to permit the individual executing the relinquishment and consent to adopt to visit or communicate with the child;

(b) that the relinquishment will result in the extinguishment of all parental rights and obligations that the individual executing the relinquishment and consent to adopt has with respect to the child, except for arrearages of child support unless the arrearages are waived by the person to whom they are owed, and that the relinquishment will remain valid whether or not any agreement for visitation or communication with the child is later performed;

(c) that the individual executing the relinquishment and consent to adopt has:

(i) received a copy of the relinquishment and consent to adopt;

(ii) received a copy of a written agreement by the department, agency, or prospective adoptive parent to accept temporary custody and to provide support and care to the child until an adoption petition is granted or denied;

(iii) if required, received counseling services pursuant to 42-2-409 explaining the meaning and consequences of an adoption;

(d) in direct parental placement adoptions, that the individual has:

(i) if a minor parent, been advised by a lawyer who is not representing the adoptive parent;

(ii) if an adult, been advised of the right to have a lawyer who is not representing the adoptive parent;

(iii) been advised that the attorney fees are
allowable expenses that can be paid by the prospective adoptive parents; and

(iv) been provided with a copy of the prospective adoptive parent's preplacement evaluation;

(e) in agency and direct parental placement adoptions, that the individual has:

(i) been advised of the obligation to provide the medical and social history information required under 42-3-101 pertaining to disclosures; and

(ii) not received or been promised any money or anything of value for execution of the relinquishment and consent to adopt, except for payments authorized by 42-7-101 and 42-7-102.

(4) A relinquishment and consent to adopt may provide that the individual who is relinquishing waives notice of any proceeding for adoption.


LIBRARY REFERENCES

Adoption 7.3, 7.5.
Westlaw Key Number Searches: 17k7.3; 17k7.5.
C.J.S. Adoption of Persons §§ 56 to 58, 62, 70 to 73.

MCA 42-2-412, MT ST 42-2-412

Current through all 2009 legislation

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END OF DOCUMENT
Except under a circumstance stated in 42-2-411 a relinquishment and consent to the adoption of a child that is executed by a parent or guardian in substantial compliance with 42-2-412 is final and irrevocable. The relinquishment and consent to adopt:

(1) unless a court orders otherwise to protect the welfare of the child, entitles the department, agency, or prospective adoptive parent named or described to the legal and physical custody of the child and imposes on that department, agency, or prospective adoptive parent responsibility for the support and medical and other care of the child;

(2) terminates, as provided in 42-2-403, any duty of the parent who executed the document with respect to the child except for arrearages of child support; and

(3) terminates any right of the parent or guardian who executed the document to:

   (a) object to the placement of the child for adoption by the department or agency; and

   (b) object to the child's adoption by the prospective adoptive parent.

Enacted by Laws 1997, ch. 480, § 52.

OFFICIAL COMMENTS

1994 Commissioners' Comment: This section specifies the general legal consequences of a consent or relinquishment and is consistent with the Act's intention to keep track of a minor and assign responsibility for the minor's care and support throughout the adoption process. If executed in substantial compliance with this Part, either document is final and irrevocable except under limited circumstances and entitles the prospective adoptive parents in a direct placement and the agency in an agency placement to the custody of the minor and requires them to provide support and care for the minor. The section also specifies the extent to which further notice of the adoption proceeding is or is not waived by a consent or relinquishment.

LIBRARY REFERENCES

Adoption $7.3, 7.5, 7.6.
Westlaw Key Number Searches: 17k7.3; 17k7.5; 17k7.6.
C.J.S. Adoption of Persons §§ 56 to 58, 62, 70 to 76.

NOTES OF DECISIONS

In general

1. In general


Failure of adoption agency to obtain Montana District Court order terminating natural mother's parental rights in Montana-born child did not preclude agency from placing child for adoption in Idaho, where, under Idaho law, only consent of natural parents was required for adoption proceeding, Idaho district court was presented with natural parents' properly executed consent to adoption and relinquishment of parental rights, and, once adoption decree was entered, parental rights were judicially terminated. MCA 40-
MCA 42-2-413, MT ST 42-2-413


MCA 42-2-413, MT ST 42-2-413

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END OF DOCUMENT
42-4-111. Custody order

(1) The court shall consider the petition to adopt and shall make a determination as to whether temporary custody should be awarded to the petitioner. In making that determination, the court shall consider:

(a) the preplacement evaluation that pertains specifically to placement of the child who is the subject of the adoption petition with the petitioner; and

(b) if any significant change in the petitioner's or child's circumstances has occurred since preparation of the preplacement evaluation.

(2) Upon a determination that it is in the best interests of the child, the court shall enter an order granting temporary custody to the prospective adoptive parent.

(3) Upon a determination that it is not in the best interests of the child to place custody with the prospective adoptive parent, the court shall deny the petition to terminate parental rights of the placing parent and shall make any other order with regard to the custody of the child that is necessary to protect the well-being of the child.

Enacted by Laws 1997, ch. 480, § 98.

LIBRARY REFERENCES

Adoption © 13, 14.
Westlaw Key Number Searches: 17k13; 17k14.
C.J.S. Adoption of Persons §§ 46 to 47, 93 to 108, 130 to 135, 140.
42-7-101. Fees related to placement for adoption by parent

(1) Reasonable adoption fees may be paid by the adoptive parent for the actual cost of services. The cost of services must relate to:

(a) a petition for adoption;
(b) placement of a child;
(c) medical care or services;
(d) prenatal care;
(e) foster care;
(f) a preplacement evaluation;
(g) counseling related to providing information necessary to make an informed decision to voluntarily relinquish a child;
(h) travel or temporary living costs for the birth mother;
(i) legal fees incurred for services on behalf of the placing parent;
(j) the reasonable costs incurred by a placing parent in a direct parental placement adoption to document the disclosures of medical and social history required by 42-3-101; and
(k) other reasonable costs related to adoption that do not include education, vehicles, salary or wages, vacations, or permanent housing for the birth parent.

(2) A birth parent or a provider of a service listed in subsection (1) may receive or accept a payment authorized by subsection (1). The payment may not be made contingent on the placement of a child for adoption or upon relinquishment of and consent to adoption of the child. If the adoption is not completed, a person who is authorized by subsection (1) to make a specific payment is not liable for that payment unless the person has agreed in a signed writing with a birth parent or a provider of a service to make the payment regardless of the outcome of the proceeding for adoption.

Enacted by Laws 1997, ch. 480, § 147.

CROSS REFERENCES

Postadoptive counseling and support, inclusion in fees related to placement for adoption, see § 42-4-211.

LIBRARY REFERENCES

Adoption k9.1.
Westlaw Key Number Search: 17k9.1.
C.J.S. Adoption of Persons §§ 46, 77.
46-4-103. Autopsy—when conducted, scope

(1) If in the opinion of the coroner an autopsy is advisable, the coroner shall order one performed on any dead human body for which the death requires an inquiry and shall retain a medical examiner or associate medical examiner to perform it. Performance of autopsies is within the discretion of the coroner except that the county attorney or attorney general may require one. Consent of the family or next of kin of the deceased is not required for an autopsy that is ordered by the coroner, county attorney, or attorney general. In ordering an autopsy the coroner, county attorney, or attorney general shall order the body to be exhumed if it has been interred.

(2) The right to conduct an autopsy includes the right to retain specimens the medical examiner performing the autopsy considers necessary.

(3) The state of Montana shall pay any expenses incurred whenever an autopsy or investigation is initiated at the request of the state medical examiner or attorney general. The county shall pay any expenses incurred whenever an autopsy, investigation, or inquiry is initiated at the request of the county attorney or county coroner.

(4) If a county does not provide a morgue or other facility for postmortem examination, the county coroner may order the use of a funeral home or an appropriate hospital facility for the examination.

(5) Autopsies performed under this section on a decedent whose death is under investigation and who has made an anatomical gift or on whose behalf an anatomical gift has been made must be performed in accordance with 72-17-217 and 72-17-218.

MCA 46-4-122, MT ST 46-4-122

MONTANA CODE ANNOTATED
TITLE 46. CRIMINAL PROCEDURE
CHAPTER 4. INVESTIGATIVE PROCEDURES
PART 1. INVESTIGATION OF DEATH --
AUTOPSY

46-4-122. Human deaths requiring
inquiry by coroner

The coroner shall inquire into and determine the
cause and manner of death and all circumstances
surrounding a human death:

(1) that was caused or is suspected to have been
caus
(a) in any degree by an injury, either recent or
remote in origin; or
(b) by the deceased or any other person that was
the result of an act or omission, including but not
limited to:
(i) a criminal or suspected criminal act;
(ii) a medically suspicious death, unusual death,
or death of unknown circumstances, including any
fetal death; or
(iii) an accidental death; or
(c) by an agent, disease, or medical condition
that poses a threat to public health;

(2) whenever the death occurred:

(a) while the deceased was incarcerated in a
prison or jail or confined to a correctional or
detention facility owned and operated by the state or
a political subdivision of the state;

(b) while the deceased was in the custody of, or
was being taken into the custody of, a law
enforcement agency or a peace officer;

(c) during or as a result of the deceased's
employment;

(d) less than 24 hours after the deceased was
admitted to a medical facility or if the deceased was
dead upon arrival at a medical facility; or

(e) in a manner that was unattended or
unwitnessed and the deceased was not attended by a
physician at any time in the 30-day period prior to
death;

(3) if the dead human body is to be cremated or
shipped into the state and lacks proper medical
certification or burial or transmit permits; or

(4) that occurred under suspicious circumstances.

History: En. Sec. 4, Ch. 660, L. 1991; amd. Sec. 2,
Ch. 287, L. 1993.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

1993 Amendment: Chapter 287 in (3) inserted
reference to shipping body into state.

Cross-References

Custody and disposition of bodies held pending
investigation, 7-4-2915.

MCA 46-4-122, MT ST 46-4-122

Current through the 2005 Regular Session of the 59th
Legislature

END OF DOCUMENT
46-4-301. Issuance of subpoena

(1) Whenever a prosecutor has a duty to investigate alleged unlawful activity, any justice of the supreme court or district court judge of this state may cause subpoenas to be issued commanding the persons to whom they are directed to appear before the prosecutor and give testimony and produce books, records, papers, documents, and other objects as may be necessary and proper to the investigation.

(2) Except as provided in subsection (3), a subpoena may be issued only when it appears upon the affidavit of the prosecutor that the administration of justice requires it to be issued.

(3) In the case of constitutionally protected material, such as but not limited to medical records or information, a subpoena may be issued only when it appears upon the affidavit of the prosecutor that a compelling state interest requires it to be issued. In order to establish a compelling state interest for the issuance of such a subpoena, the prosecutor shall state facts and circumstances sufficient to support probable cause to believe that:

(a) an offense has been committed; and

(b) the information relative to the commission of that offense is in the possession of the person or institution to whom the subpoena is directed.

History: En. 95-720 by Sec. 1, Ch. 486, L. 1977; R.C.M. 1947, 95-720(1); amd. Sec. 19, Ch. 800, L. 1991; amd. Sec. 1, Ch. 318, L. 1999.

Compiler's Comments

1999 Amendment: Chapter 318 in (2) at beginning inserted exception clause; inserted (3) clarifying the showing necessary for the discovery of constitutionally protected material; and made minor changes in style. Amendment effective April 16, 1999.

Preamble: The preamble attached to Ch. 318, L. 1999, provided: "WHEREAS, in State v. Nelson, 283 Mont. 231, 941 P.2d 441, 54 St. Rep. 576 (1997), the Montana Supreme Court held that discovery of constitutionally protected material, such as medical records, requires a showing of a compelling state interest."

1991 Amendment: In three places substituted references to prosecutor for references to Attorney General or County Attorney; and made minor changes in style.

Case Notes

Revealing Limited Medical Information During Police Interview Not Considered Waiver of Constitutional Right to Confidentiality in Medical Records -- Voluntary Medical Information Outside Scope of Fruit of Poisonous Tree Doctrine -- Adequate Probable Cause for Investigative Subpoena of Medical Records: Bilant was involved in a three-car accident and was subsequently arrested for DUI and a seat belt violation. During an interview following the arrest, Bilant revealed to an officer that he had taken pain medication on the day of the accident. The officer called Bilant's health care provider for confirmation, and the provider confirmed that Bilant had a prescription for a drug similar to the pain medication that he mentioned. The officer then procured an investigative subpoena regarding documentation on all prescriptions issued to Bilant, including any advisory warnings, and the provider sent Bilant's entire medical file. Bilant contended that the state violated both his constitutional right to privacy and the statutory protections of 50-16-535. The state maintained that Bilant waived his claim of confidentiality in his medical information when he voluntarily revealed his use of pain medication to the officer. The Supreme Court agreed with Bilant. Medical records are quintessentially private and deserve the utmost constitutional protection. None of the statutory prerequisites for disclosure of the medical records were met. In deciding to reveal limited medical information in a police interview, Bilant did not forfeit his constitutional right to subsequently claim confidentiality in his medical records. The officer conducted an illegal search in seeking the constitutionally protected private medical information without probable cause and the benefit of an investigative subpoena under this section, and the information gleaned from the telephone call should
have been suppressed. Bilant then contended that the use of the illegally obtained information formed an improper basis for the investigative subpoena and that the results of the subpoena should also have been suppressed pursuant to the fruit of the poisonous tree doctrine, which forbids the use of evidence that comes to light as the result of an initially illegal act. However, on this point, the Supreme Court disagreed with Bilant. One exception to the doctrine is that the derivative evidence is admissible if it is obtained from an independent source. Here, Bilant himself provided the source by giving voluntary medical information from other than the illegal telephone inquiry. The Supreme Court recognized that an investigative subpoena seeking constitutionally protected medical information requires greater justification for state access than the administration of justice rationale used to obtain public information under this section, so in reviewing the probable cause basis for constitutionally protected material, the court excised the illegal evidence from the application and reviewed the remaining information de novo to determine whether probable cause existed for issuing the subpoena. In this case, even when the information subject to suppression was excised, the remaining evidence established probable cause that a DUI was committed and underscored a compelling state interest in medical records related to prescription medicines in order to confirm Bilant's initial interest in medical records related to prescription medicines. The court stated that the erroneous conclusions contained within the application did not invalidate the remaining information and declined to extend the exclusionary rule to investigative subpoenas.

Jurisdiction to Issue Investigative Subpoenas: The plain language of 46-4-301 vests every District Court Judge with the power to issue investigative subpoenas with no jurisdictional limitation. There is no requirement, explicit or implicit, that the subpoena be issued by the sitting judge of the district where the crime allegedly occurred. The venue statutes have no application to the jurisdictions of any District Court to issue such subpoenas, which jurisdiction is coextensive with the state boundaries.

Availability of Investigative Subpoena: A subpoena must be issued by a court and is not available to the Attorney General or other prosecuting attorneys independent of a court or grand jury. Under former law, a subpoena was not available in cases not filed.

MCA 46-4-301, MT ST 46-4-301

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
The administrator of a hospital licensed under this chapter shall as a condition of licensure under 50-5-201:

(1) establish a written protocol for the identification of potential organ donors that:

(a) ensures that families of potential organ donors are made aware of the option of organ or tissue donation and their option to decline;

(b) encourages discretion and sensitivity with respect to the circumstances, views, and beliefs of families of potential organ donors; and

(c) requires that a qualified organ procurement agency be notified of potential organ donors;

(2) designate and train a person or persons to represent the administrator for purposes of requesting an anatomical gift as provided in 72-17-213; and

(3) make known to the public that the hospital has an organ procurement program as described in subsection (1).


ADMINISTRATIVE CODE REFERENCES

Definitions, see MT ADC 37.106.301.

LIBRARY REFERENCES

Dead Bodies §1.
Health §236, 256.
Westlaw Key Number Searches: 116k1; 198Hk236; 198Hk256.
C.J.S. Dead Bodies §§ 1 to 3.
C.J.S. Hospitals §§ 6 to 10, 18.


As used in this part:

(1) "person" includes one or more individuals, partnerships, associations, and corporations;

(2) "sterilization" means the performance of, assistance or participation in the performance of, or submission to an act or operation intended to eliminate an individual's reproductive capacity.

History: En. 69-5222 by Sec. 1, Ch. 247, L. 1974; R.C.M. 1947, 69-5222.
50-5-502. Refusal by hospital or health care facility to participate in sterilization

(1) No private hospital or health care facility shall be required, contrary to the religious or moral tenets or the stated religious beliefs or moral convictions of such hospital or facility as stated by its governing body or board, to admit any person for the purpose of sterilization or to permit the use of its facilities for such purpose.

(2) Such refusal shall not give rise to liability of such hospital or health care facility or any personnel or agent or governing board thereof to any person for damages allegedly arising from such refusal or be the basis for any discriminatory, disciplinary, or other recriminatory action against such hospital or health care facility or any personnel, agent, or governing board thereof.

History: En. 69-5223 by Sec. 2, Ch. 247, L. 1974; R.C.M. 1947, 69-5223(1).

NOTES, REFERENCES, AND ANNOTATIONS

Cross-References

Freedom of religion, Art. 11, sec. 5, Mont. Const.

Liability, Title 27, ch. 1, part 7.

Right to refuse participation in abortion, 50-20-111.

Case Notes

Sterilization -- Doctor Subject to Hospital Morality Rules: With respect to the issue of voluntary sterilization, although the physician has exclusive direction over his patient, he is subject to hospital rules based upon religious or moral tenets. Ham v. Holy Rosary Hosp., 165 M 369, 529 P2d 361

MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 5. HOSPITALS AND RELATED FACILITIES
PART 5. RIGHT TO REFUSE PARTICIPATION IN STERILIZATION

50-5-503. Refusal by individual to participate in sterilization

(1) All persons shall have the right to refuse to advise concerning, perform, assist, or participate in sterilization because of religious beliefs or moral convictions.

(2) If requested by any hospital or health care facility or person desiring sterilization, such refusal shall be in writing signed by the person refusing but may refer generally to the grounds of "religious beliefs and moral convictions".

(3) The refusal of any person to advise concerning, perform, assist, or participate in sterilization shall not be a consideration in respect of staff privileges of any hospital or health care facility or a basis for any discriminatory, disciplinary, or other recriminatory action against such person, nor shall such person be liable to any person for damages allegedly arising from refusal.

History: En. 69-5223 by Sec. 2, Ch. 247, L. 1974; R.C.M. 1947, 69-5223(2).
MCA 50-5-504, MT ST 50-5-504

MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 5. HOSPITALS AND RELATED FACILITIES
PART 5. RIGHT TO REFUSE PARTICIPATION IN STERILIZATION

50-5-504. Unlawful to interfere with right of refusal

(1) It shall be unlawful to interfere or attempt to interfere with the right of refusal authorized by this part, whether by duress, coercion, or any other means.

(2) The person injured thereby shall be entitled to injunctive relief, when appropriate, and shall further be entitled to monetary damages for injuries suffered.

History: En. 69-5223 by Sec. 2, Ch. 247, L. 1974; R.C.M. 1947, 69-5223(3).

NOTES, REFERENCES, AND ANNOTATIONS

Cross-References

Injunctions, Title 27, ch. 19.

Termination of employment, Title 39, ch. 2, part 5.

Case Notes

Evidence to Support Award of Exemplary Damages and Damages for Mental Distress: Plaintiff's employment as a nurse-anesthetist was terminated by defendant hospital for plaintiff's refusal to participate in a tubal ligation. In an action for damages, the plaintiff introduced evidence of her projected future earnings. The District Court failed to award future damages and gave no reasons for its decision. It must be assumed that the District Court was aware of its power to award future damages under 27-1-203 but did not feel such damages were reasonably certain to occur. Swanson v. St. John's Lutheran Hosp., 189 M 259, 615 P2d 883, 37 St. Rep. 1420 (1980).

Theory for Determining Damages: This section creates a statutory right to receive damages above and beyond the employment contract. A compensation theory is to be used with future damages, exemplary damages, and damages for mental distress allowable in the proper case. Swanson v. St. John's Lutheran Hosp., 189 M 259, 615 P2d 883, 37 St. Rep. 1420 (1980).

Burden of Producing Evidence: Once a discharged hospital employee had established that her discharge was brought about in substantial part by her refusal to participate in a sterilization, it then became the burden of the hospital to prove by a preponderance of the evidence that it would have discharged the employee even if she had not exercised her right of refusal. Swanson v. St. John's Lutheran Hosp., 182 M 414, 597 P2d 702 (1979).

Rights of Employees Preeminent: The "rights" of the hospital to avoid the difficulties of finding substitutes for employees who refuse to participate in a sterilization do not outweigh the rights of employees to refuse to participate. Swanson v. St. John's Lutheran Hosp., 182 M 414, 597 P2d 702 (1979).

MCA 50-5-504, MT ST 50-5-504

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MCA 50-5-505, MT ST 50-5-505

50-5-505. Refusal not grounds for loss of privileges, immunities, or public benefits

Such refusal by any hospital or health care facility or person shall not be grounds for loss of any privileges or immunities to which the granting of consent may otherwise be a condition precedent or for the loss of any public benefits.

History: En. 69-5223 by Sec. 2, Ch. 247, L. 1974; R.C.M. 1947, 69-5223(4).

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
50-5-1201. Use of safety devices -- request and consent -- allowed individuals -- intent

(1) The following individuals may request the use of and provide informed consent for the use of certain safety devices aimed at ensuring the physical safety of the resident by reducing the risk of falls and injuries associated with a resident's medical symptom even if the resident cannot easily remove the device or the device restricts the resident's total freedom of movement:

(a) a resident;

(b) a family member of a resident who is unable to make decisions because the resident has a communication barrier or has been found by a physician to be medically incapable of granting informed consent, as provided in 50-5-1203;

(c) a guardian, as defined in 72-1-103; or

(d) a person granted the power of attorney for health care decisions.

(2) A concern for a resident's physical safety or a resident's fear of falling may provide the basis for a medical symptom. A safety device may not be used for the convenience of staff or for disciplinary purposes.

(3) This part is intended to provide residents and authorized or designated representatives with the authority to request and consent to the use of safety devices but is not intended to interfere with the right of licensed health care providers acting within their scope of practice to recommend and order treatments and services, including physical restraints, for residents in their care.

History: En. Sec. 1, Ch. 347, L. 2001.
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 5. HOSPITALS AND RELATED
FACILITIES
PART 12. SAFETY DEVICES IN LONG-TERM
CARE FACILITIES

50-5-1202, Definitions

As used in this part, the following definitions apply:

(1) "Department" means the department of public health and human services provided for in 2-15-2201.

(2) "Long-term care facility" means a licensed facility that provides skilled nursing care or intermediate nursing care or that is an assisted living facility, as defined in 50-5-101.

(3) "Medical symptom" means an indication of a physical or psychological condition or of a physical or psychological need expressed by the patient.

(4) "Physician" includes an advanced practice registered nurse to the extent permitted by federal law.

(5) "Resident" means a person who lives in a long-term care facility.

(6) (a) "Safety devices" means side rails, tray tables, seatbelts, and other similar devices.

(b) The term does not include protective restraints as defined in 21 CFR 880.6760.

History: En. Sec. 2, Ch. 347, L. 2001; amd. Sec. 6, Ch. 54, L. 2003.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

2003 Amendment: Chapter 54 in definition of long-term care facility near middle after "that is" substituted "an assisted living" for "a personal care". Amendment effective October 1, 2003.
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 5. HOSPITALS AND RELATED FACILITIES
PART 12. SAFETY DEVICES IN LONG-TERM CARE FACILITIES

50-5-1203. Procedures -- informed consent -- physician involvement

(1) Upon receiving a request for use of a safety device, a long-term care facility shall inform the requestor of the alternatives and risks associated with the use of the safety device. The long-term care facility shall provide the requested safety device to the resident upon receipt of:

(a) a signed consent form authorizing its use and acknowledging receipt of specific information about available alternatives and risks; and

(b) a written order from the attending physician that specifies the circumstances under and the duration for which the safety device may be used and the medical symptoms that the safety device is intended to address.

(2) The requirements of subsection (1) do not apply if a side rail or other device is used only as an assistive device and does not restrict the resident's movement from bed or chair.


<General Materials (GM) - References, Annotations, or Tables>

MCA 50-5-1203, MT ST 50-5-1203

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
A long-term care facility that provides a safety device under 50-5-1203 shall:

1. document that the procedures outlined in 50-5-1203 have been followed;

2. monitor the use of the safety device in accordance with accepted standards of practice;

3. reevaluate the resident's need for the safety device, no less than quarterly, in consultation with the resident, the resident's family, and the attending physician.

History: En. Sec. 4, Ch. 347, L. 2001.
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 5. HOSPITALS AND RELATED FACILITIES
PART 12. SAFETY DEVICES IN LONG-TERM CARE FACILITIES

50-5-1205. Survey compliance and department enforcement -- rulemaking authority

(1) The department is granted rulemaking authority for the purposes of implementing this part.

(2) When determining compliance with state and federal standards for the use of a safety device, the department is bound by the statements and determinations contained in the attending physician's order regarding medical symptoms. A written order from the attending physician that contains statements and determinations regarding medical symptoms is sufficient evidence of the medical necessity of the safety device.

(3) A long-term care facility may not be subject to fines, civil penalties, or other state or federal survey enforcement remedies solely as the result of allowing the use of a safety device as authorized in this part.

(4) This section does not preclude the department from taking action to protect the safety and health of the resident if there is clear and convincing evidence that:

   (a) the use of the safety device has jeopardized the health and safety of the resident; and

   (b) the long-term care facility has failed to take reasonable measures to protect the health and safety of the resident.

History: En. Sec. 5, Ch. 347, L. 2001.
50-9-103. Declaration relating to use of life-sustaining treatment—designee

(1) An individual of sound mind and 18 years of age or older may execute at any time a declaration governing the withholding or withdrawal of life-sustaining treatment. The declarant may designate another individual of sound mind and 18 years of age or older to make decisions governing the withholding or withdrawal of life-sustaining treatment. The declaration must be signed by the declarant or another at the declarant's direction and must be witnessed by two individuals. A health care provider may presume, in the absence of actual notice to the contrary, that the declaration complies with this chapter and is valid.

(2) A declaration directing a physician or advanced practice registered nurse to withhold or withdraw life-sustaining treatment may but need not be in the following form:

DECLARATION

If I should have an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician or attending advanced practice registered nurse, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician or attending advanced practice registered nurse, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

Signed this .... day of ........, .....  
Signature ...............  

City, County, and State of Residence ....................

The declarant voluntarily signed this document in my presence.

Witness.........................

Address.............................

Witness.............................

Address.............................

(3) A declaration that designates another individual to make decisions governing the withholding or withdrawal of life-sustaining treatment may but need not be in the following form:

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician or attending advanced practice registered nurse, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I appoint .......... or, if that person is not reasonably available or is unwilling to serve, .........., to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain, pursuant to the Montana Rights of the Terminally Ill Act.

If the individual I have appointed is not reasonably available or is unwilling to serve, I direct my attending physician or attending advanced practice registered nurse, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

Signed this .... day of ........, .....  
Signature.........................
City, County, and State of Residence

The declarant voluntarily signed this document in my presence.

Witness

Address

Witness

Address

Name and address of designee.

Name

Address

(4) If the designation of an attorney-in-fact pursuant to 72-5-501 and 72-5-502 or the judicial appointment of an individual contains written authorization to make decisions regarding the withholding or withdrawal of life-sustaining treatment, that designation or appointment constitutes, for the purposes of this part, a declaration designating another individual to act for the declarant pursuant to subsection (1).

(5) A health care provider who is furnished a copy of the declaration shall make it a part of the declarant's medical record and, if unwilling to comply with the declaration, shall advise the declarant and any individual designated to act for the declarant promptly.


COMMISSIONER'S COMMENTS

Section 2 [50-9-103] sets out the minimal requirements regarding the making and execution of a valid declaration. "Sample" declaration forms are offered in this section. The forms are not mandatory, as some acts require; they "may, but need not, be" followed. The forms provided also are not as elaborate as others. The drafters rejected more detailed declarations for two reasons. First, the forms are to serve only as examples of a valid declaration. More elaborate forms may have erroneously implied that a declaration more simply constructed would not be legally sufficient. Second, the sample forms' simple structure and specific language attempt to provide notice of exactly what is to be effectuated through these documents to those persons desiring to execute a declaration and the physicians who are to honor it.

Sections 2(a) and (c) [50-9-103(1) and (3)] of the Act authorize an individual by a declaration to designate another person to make decisions governing the withholding or withdrawal of life-sustaining care. The designated person must be an adult of sound mind, but no other restrictions are placed on the designation other than the requirements of form contained in Section 2(a) [50-9-103(1)]. The designated person may be an attorney-in-fact who is so designated in the declaration or in another writing that conforms with the applicable requirements of each state for durable powers of attorney.

Section 2(c) [50-9-103(3)] provides a model form of declaration by which the designation of another decision-maker may be accomplished. The bracketed language in the Section 2(c) [50-9-103(3)] form of declaration is intended to allow a declarant two choices when designating another person to make treatment decisions. First, by striking the bracketed language, an individual may make an exclusive designation of another decision-maker, and if that person is not available to fulfill the responsibility, the declaration will have no effect. It is intended, in such an event, that the substituted decision-makers who are authorized to make treatment decisions in Section 7 [50-9-106] will be able to exercise decision-making authority pursuant to the terms of Section 7 [50-9-106]. The execution of a declaration exclusively designating another person to make treatment decisions, in other words, should not itself be construed as an "expressed intention of the individual" not to have life-sustaining treatment withheld or withdrawn under Section 7(d) [50-9-106(4)].

The second choice available in the Section 2(c) [50-9-103(3)] form of declaration would make the declaration directly effective by its terms in the event that acts require; they "may, but need not, be" followed. The forms provided also are not as elaborate as others. The drafters rejected more detailed declarations for two reasons. First, the forms
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The second choice available in the Section 2(c) [50-9-103(3)] form of declaration would make the declaration directly effective by its terms in the event that withdrawal of treatment for a person in a persistent vegetative state not covered by the terms of the Act, the Act's limitations would not circumscribe the attorney-in-fact's authority under other law.

In designating another person to make treatment decisions, it is assumed that a declarant will identify only a single decision-maker. In view of this assumption, Sections 2(a) and (c) [50-9-103(1) and (3)] permit designation of an individual, rather than individuals, as the problems associated with identifying, locating, and communicating with multiple decision-makers are substantial and the drafters did not want to encourage the practice.

The Act does not expressly prohibit multiple designees, however, and a declaration containing a multiple designation is not invalid under the Act. The absence of any provision permitting a majority of such designees to act in the case of a disagreement, however, means that the refusal of one member of a designee group to agree to direct the withholding or withdrawal of treatment will foreclose any action under the Act unless the declaration specifically provides otherwise. Because of the difficulties associated with multiple designees under the Act, declarants should be discouraged from the practice and, if such designations are made and any result other than the one stated above is desired, the declaration should so specify.

The Act's provisions governing witnesses to a declaration are simplified. Section 2 [50-9-103] provides only that the declaration be signed by the declarant in the presence of two witnesses. The Act does not require witnesses to meet any specific qualifications for two primary reasons. First, the interest in simplicity mandates as uncomplicated a procedure as possible. It is intended that the Act present a viable alternative for those persons interested in participating in their medical treatment decisions in the event of a terminal condition.

Second, the absence of more elaborate witness requirements relieves physicians of the inappropriate and perhaps impossible burden of determining whether the legalities of the witness requirements have been met. Many physicians understandably and rightly would be hesitant to make such decisions and, therefore, the effectiveness of the declaration might be jeopardized. It should be noted, as well, that protection against abuse in these situations is provided by the criminal penalties in Section 10 [50-9-206]. The attending physicians and other health-care professionals will be able, in most
circumstances, to discuss the declaration with the patient and family, and any suspicion of duress or wrongdoing can be discovered and handled by established hospital procedures.

Section 2(e) [50-9-103(5)] requires that a physician or health-care provider who is given a copy of the declaration record it in the declarant's medical records. This step is critical to the effectuation of the declaration, and the duty applies regardless of the time of receipt. If a copy of the same declaration is already in the record, its re-recording would not be necessary, but its receipt should be noted as evidence of its continued force. Section 2(e) [50-9-103(5)] is not duplicative of Section 5 [50-9-201] which requires recording the terms of the declaration (or the document itself, when available, in the event of telephonic communication to the physician by another physician, for example) at the time the physician makes a determination of terminal condition. It was deemed important that knowledge of the declaration and its continued force be specifically noted at this critical juncture.

Section 2(e) [50-9-103(5)] imposes a duty on the physician or other health-care provider to inform the declarant of his or her unwillingness to comply with the provisions of the declaration. This will provide notice to the declarant that certain terms may be deemed medically unreasonable (Section 11(f) [50-9-205(6)]), or that the declarant should decide whether to select another attending physician who is willing to carry out the Act (Section 8 [50-9-203]).

ADMINISTRATIVE CODE REFERENCES

Definitions, see MT ADC 37.10.101, MT ADC 37.34.102.

Living will protocol for EMS personnel, see MT ADC 37.10.104.

LAW REVIEW AND JOURNAL COMMENTARIES


LIBRARY REFERENCES

Health ©916.

(1) A declarant may revoke a declaration at any time and in any manner, without regard to mental or physical condition. A revocation is effective upon its communication to the attending physician, attending advanced practice registered nurse, or other health care provider by the declarant or a witness to the revocation. A health care provider or emergency medical services personnel witnessing a revocation shall act upon the revocation and shall communicate the revocation to the attending physician or attending advanced practice registered nurse at the earliest opportunity. A revocation communicated to a person other than the attending physician, attending advanced practice registered nurse, emergency medical services personnel, or health care provider is not effective unless the attending physician or attending advanced practice registered nurse is informed of it before the qualified patient is in need of life-sustaining treatment.

(2) The attending physician, attending advanced practice registered nurse, or other health care provider shall make the revocation a part of the declarant's medical record.


Compiler's Comments

2003 Amendment: Chapter 240 in (1) in four places and in (2) near beginning after "physician" inserted "attending advanced practice registered nurse"; and made minor changes in style. Amendment effective October 1, 2003.

1991 Amendment: In (1), in first sentence after "manner", deleted "by which the declarant is able to communicate his intent to revoke", in second sentence, after "effective", deleted "only as to the attending physician or any health care provider acting under the guidance of that physician" and before "physician" inserted "attending", and in fourth sentence, at end, substituted "treatment" for "procedures"; and made minor changes in style. Amendment effective April 8, 1991.

Source: Section 4, Uniform Rights of the Terminally Ill Act.

1989 Amendment: Inserted third and fourth sentences of (1) clarifying actions required of witnesses to a revocation. Amendment effective April 8, 1989.

Collateral References

MCA 50-9-104, MT ST 50-9-104

Judicial power to order discontinuance of life-sustaining treatment. 48 ALR 4th 67.

Patient's right to refuse treatment allegedly necessary to sustain life. 93 ALR 3d 67.

Power of court to order or authorize discontinuation of extraordinary medical means of sustaining human life. 79 ALR 3d 237, superseded by 48 ALR 4th 67.

MCA 50-9-104, MT ST 50-9-104

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
50-9-106. Consent by others to withholding or withdrawal of treatment

(1) If a written consent to the withholding or withdrawal of the treatment, witnessed by two individuals, is given to the attending physician or attending advanced practice registered nurse, the attending physician or attending advanced practice registered nurse may withhold or withdraw life-sustaining treatment from an individual who:

(a) has been determined by the attending physician or attending advanced practice registered nurse to be in a terminal condition and no longer able to make decisions regarding administration of life-sustaining treatment; and

(b) has no effective declaration.

(2) The authority to consent or to withhold consent under subsection (1) may be exercised by the following individuals, in order of priority:

(a) the spouse of the individual;

(b) an adult child of the individual or, if there is more than one adult child, a majority of the adult children who are reasonably available for consultation;

(c) the parents of the individual;

(d) an adult sibling of the individual or, if there is more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation; or

(e) the nearest other adult relative of the individual by blood or adoption who is reasonably available for consultation.

(3) A full guardian may consent or withhold consent under subsection (1) as provided in 72-5-321.

(4) If a class entitled to decide whether to consent is not reasonably available for consultation and competent to decide or if it declines to decide, the next class is authorized to decide. However, an equal division in a class does not authorize the next class to decide.

(5) A decision to grant or withhold consent must be made in good faith. A consent is not valid if it conflicts with the expressed intention of the individual.

(6) A decision of the attending physician or attending advanced practice registered nurse acting in good faith that a consent is valid or invalid is conclusive.

(7) Life-sustaining treatment cannot be withheld or withdrawn pursuant to this section from an individual known to the attending physician or attending advanced practice registered nurse to be pregnant so long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment.


COMMISSIONER'S COMMENTS

Section 7 [50-9-106] provides a procedure by which an attending physician may obtain consent to the withholding or withdrawal of life-sustaining treatment in the absence of an effective declaration. It draws upon the definitions of the Act, as well as those sections bearing on the process for and the legal effect of withholding or withdrawal of treatment, but in most other respects it is free-standing. It can therefore simply be inserted as a new section in existing statutes that follow the original 1985 Uniform Act. For states that might want to adopt the Section 2 [50-9-103] amendments, but not the Section 7 [50-9-106] amendments, Section 7 [50-9-106] can simply be deleted.

The purpose of Section 7 [50-9-106] is to authorize persons other than the patient who are in a close familial relationship to the patient to consent to the withholding or withdrawal of life-sustaining
treatment when the patient has no prior declaration, or when a prior declaration is not effective. Prior declarations might not be effective for a variety of reasons, including for example the expiration of a time limit, the failure to have the declaration properly witnessed, or the absence of a condition precedent contained in the declaration, such as the death or disability of a designated decision-maker.

Section 7 [50-9-106] authorizes binding consent to the withholding or withdrawal of life-sustaining treatment for qualified patients. Members of the patient's family in designated priority order may consent to withholding or withdrawal of life-sustaining treatment, and such consent will be treated as if the individual had given it. Consent by the designated family members, however, must be given in good faith, and is not valid if it would conflict with the expressed intention of the patient.

The consent provision of section 7 [50-9-106] differs from the designation of another to make decisions under Section 2 [50-9-103]. Because the "consent" does not constitute a declaration under the Act, provisions that impose an obligation on the physician to seek out a designee under a declaration, that make the designee's decisions "govern" treatment, and that require transfer by a physician under Section 8 [50-9-203], do not apply. Section 7 [50-9-106], in short, is not a full alternative to a declaration, but is rather a means by which the attending physician can obtain legally reliable consent to the withholding or withdrawal of treatment for individuals in a terminal condition, should that be needed in the circumstances. Section 7 [50-9-106] neither constitutes a de jure appointment of family to make such decisions in all cases, nor does it limit treatment authority authorized under other law.

ADMINISTRATIVE CODE REFERENCES

Definitions, see MT ADC 37.10.101.

LIBRARY REFERENCES

Health 916.
Westlaw Key Number Search: 198Hk916.
C.J.S. Right to Die §§ 2, 5, 7, 13 to 14, 18 to 25, 31 to 32, 35 to 39, 43, 48, 50 to 51.

RESEARCH REFERENCES

Encyclopedias


63 Am. Jur. Trials 1, Decisionmaking at the End of Life.

Treatises and Practice Aids

Advising the Elderly Client § 33:43, Surrogate Consent Statutes.


MCA 50-9-106, MT ST 50-9-106

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END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 9. RIGHTS OF THE TERMINALLY ILL ACT
PART 1. GENERAL

50-9-111. Recognition of declarations executed in other states

A declaration executed in a manner substantially similar to 50-9-103 in another state and in compliance with the law of that state is effective for purposes of this chapter.

History: En. Sec. 11, Ch. 369, L. 1985.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Commissioner's Comments

Section 13 [50-9-111] provides that a declaration executed in another state, which meets the execution requirements of that other state or the enacting state (adult, two witnesses, voluntary), is to be treated as validly executed in the enacting state, but its operation in the enacting state shall be subject to the substantive policies in the enacting state's law.

Compiler's Comments

Source: Section 13, Uniform Rights of the Terminally Ill Act.

Collateral References

22A Am. Jur. 2d Death § 556.

MCA 50-9-111, MT ST 50-9-111

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
Section 8 [50-9-203] is designed to address situations in which a physician or health-care provider is unwilling to make and record a determination of terminal condition, or to respect the medically reasonable decisions of the patient or designee regarding withholding or withdrawal of life-sustaining procedures, due to personal convictions or policies unrelated to medical judgment called for under the Act. In such instances, the physician or health-care provider must promptly take all reasonable steps to transfer the patient to another physician or health-care provider who will comply with the applicable provisions of the Act.

Compiler's Comments

2003 Amendment: Chapter 240 in first sentence near beginning after "physician" inserted "attending advanced practice registered nurse" and near middle after "physician" inserted "advanced practice registered nurse"; and made minor changes in style.
(1) An individual or a person designated by the individual may file with the attorney general, for entry into the health care declaration registry, a declaration provided for in 50-9-103 that pertains to life-sustaining treatment.

(2) (a) The attorney general may accept gifts, grants, donations, bequests, and other forms of voluntary contributions to support, promote, and maintain the registry.

(b) There is a health care declaration account in the state special revenue fund. Money received pursuant to subsection (2)(a) and any money transferred from the general fund to the health care declaration registry must be deposited in the account and must be used by the attorney general to create and maintain the health care declaration registry and to create and maintain an education and outreach program for the public regarding advance health care planning and end-of-life health care decisionmaking.

(3) (a) Failure to file the declaration with the attorney general does not affect the validity of the declaration.

(b) Failure to notify the attorney general of a revocation of the declaration made pursuant to 50-9-104, does not affect the validity of the revocation.

(4) A health care provider is not required to access the registry in order to determine if a qualified patient has filed a declaration with the attorney general.

History: En. Sec. 2, Ch. 447, L. 2005.

MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 15. VITAL STATISTICS
PART 1. GENERAL PROVISIONS

50-15-101. Definitions

Unless the context requires otherwise, in parts 1 through 4, the following definitions apply:

(1) "Advanced practice registered nurse" means an individual who has been certified as an advanced practice registered nurse as provided in 37-8-202.

(2) "Authorized representative" means a person:

(a) designated by an individual, in a notarized written document, to have access to the individual's vital records;

(b) who has a general power of attorney for an individual; or

(c) appointed by a court to manage the personal or financial affairs of an individual.

(3) "Dead body" means a human body or parts of a human body from which it reasonably may be concluded that death occurred.

(4) "Department" means the department of public health and human services provided for in 2-15-2201.

(5) "Dissolution of marriage" means a marriage terminated pursuant to Title 40, chapter 4, part 1.

(6) "Fetal death" means death of the fetus prior to the complete expulsion or extraction from its mother as a product of conception, notwithstanding the duration of pregnancy. The death is indicated by the fact that after expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. Heartbeats are distinguished from transient cardiac contractions. Respirations are distinguished from fleeting respiratory efforts or gasps.

(7) "Final disposition" means the burial, interment, cremation, removal from the state, or other authorized disposition of a dead body or fetus.

(8) "Invalid marriage" means a marriage decreed by a district court to be invalid for the reasons contained in 40-1-402.

(9) "Live birth" means the complete expulsion or extraction from the mother as a product of conception, notwithstanding the duration of pregnancy. The birth is indicated by the fact that after expulsion or extraction, the child breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. Heartbeats are distinguished from transient cardiac contractions. Respirations are distinguished from fleeting respiratory efforts or gasps.

(10) "Local registrar" means a person appointed by the department to act as its agent in administering this chapter in the area set forth in the letter of appointment.

(11) "Person in charge of disposition of a dead body" means a person who places or causes a dead body or the ashes after cremation to be placed in a grave, vault, urn, or other receptacle or otherwise disposes of the body or fetus and who is a funeral director licensed under Title 37, chapter 19, an employee acting for a funeral director, or a person who first assumes custody of a dead body or fetus.

(12) "Physician" means a person legally authorized to practice medicine in this state.

(13) "Registration" means the process by which vital records are completed, filed, and incorporated into the official records of the department.

(14) "Research" means a systematic investigation designed primarily to develop or contribute to generalizable knowledge.

(15)(a) "Stillbirth" means a fetal death occurring after a minimum of 20 weeks of gestation.

(b) The term does not include an abortion, as defined in 50-20-104.

(16) "System of vital statistics" means the registration, collection, preservation, amendment, and certification of vital records. The term includes the collection of reports required by this chapter and related activities, including the tabulation, analysis, publication, and dissemination of vital statistics.
(17) "Vital records" means certificates or reports of birth, death, fetal death, marriage, and dissolution of marriage and related reports.

(18) "Vital statistics" means the data derived from certificates or reports of birth, death, fetal death, induced termination of pregnancy, marriage, and dissolution of marriage and related reports.


HISTORICAL AND STATUTORY NOTES

Laws 2007, ch. 474, § 2, inserted definition of stillbirth.

ADMINISTRATIVE CODE REFERENCES

Certificate of birth resulting in a stillbirth, see MT ADC 37.8.307.

Definitions, see MT ADC 37.8.102.
50-15-403. Preparation and filing of death or fetal death certificate

(1) A person in charge of disposition of a dead body or fetus that weighs at least 350 grams at death or, if the weight is unknown, has reached 20 completed weeks of gestation at death shall obtain personal data on the deceased, including the deceased's social security number, if any, or, in the case of a fetal death, on the parents that is required by the department from persons best qualified to supply the data and enter it on the death or fetal death certificate.

(2) The person in charge of disposition of the dead body or fetus shall present the death certificate to the certifying physician, the certifying advanced practice registered nurse, or the coroner having jurisdiction for medical certification of the cause of death. The medical certification must be completed by the physician, the advanced practice registered nurse, or the coroner within the timeframe established by the department by rule. The person in charge of disposition shall obtain the completed certification of the cause of death from the physician, the advanced practice registered nurse, or the coroner and shall, within the time that the department may prescribe by rule, file the death or fetal death certificate with the local registrar in the registration area where the death occurred or, if the place of death is unknown, where the dead body was discovered.

(3) If a dead body is found in this state but the place of death is unknown, the place where the body is found must be shown as the place of death on the death certificate. If the date of death is unknown, then the approximate date must be entered on the certificate. If the date cannot be approximated, the date that the body was found must be entered as the date of death, and the certificate must indicate that fact.

(4) When a death occurs in a moving vehicle, as defined in 45-2-101, in the United States and the body is first removed from the vehicle in this state, the death must be registered in this state and the place where the body is first removed is considered the place of death. When a death occurs in a moving vehicle while in international air space or in a foreign country or its air space and the body is first removed from the vehicle in this state, the death must be registered in this state, but the actual place of death, insofar as it can be determined, must be entered on the death certificate.

History: En. Sec. 65, Ch. 197, L. 1967; amd. Sec. 107, Ch. 349, L. 1974; R.C.M. 1947, 69-4425; amd. Sec. 28, Ch. 7, L. 1979; amd. Sec. 3, Ch. 287, L. 1993; amd. Sec. 17, Ch. 515, L. 1995; amd. Sec. 2, Ch. 118, L. 1997; amd. Sec. 93, Ch. 552, L. 1997; amd. Sec. 2, Ch. 27, L. 1999; amd. Sec. 2, Ch. 258, L. 2001.

Compiler's Comments

2001 Amendment: Chapter 258 in (2) in first sentence after "physician" inserted "the certifying advanced practice registered nurse" and in second and third sentences inserted references to advanced practice registered nurses. Amendment effective October 1, 2001.

1999 Amendment: Chapter 27 in (1) after "on the deceased" inserted ", including the deceased's social security number, if any". Amendment effective January 1, 2001, unless contingency occurs. The codifier has bracketed the amendment.

Effective Date -- Contingent Termination: Section 3(2), Ch. 27, L. 1999, provided: "(2) [Section 2] [this section] is effective January 1, 2001, unless prior to that date the director of the department of public health and human services certifies to the governor and the secretary of state in writing that the federal government has granted this state an exemption from the requirement to have a social security number on a death certificate and the exemption covers the period January 1, 2001, through July 1, 2001, in which case [section 2] [this section] is void." An exemption was not received by January 1, 2001, so the previously bracketed language contained in [section 2] referring to a person's social security number became effective.

1997 Amendments: Chapter 118 in (2) inserted second sentence concerning completion of medical certification and at end of third sentence inserted "or, if the place of death is unknown, where the dead
body was discovered”; inserted (3) concerning dead body found in the state where place of death is unknown; inserted (4) concerning death occurring in a moving vehicle; and made minor changes in style.

Chapter 552 in (1) inserted "including the deceased's social security number, if any". Amendment effective July 1, 1997. Amendment terminated April 24, 1998, pursuant to section 104(4)(d), Ch. 552, L. 1997.

Contingent Termination -- Request for Federal Exemptions: Section 104, Ch. 552, L. 1997, contained the following contingent termination provisions and order that the Department of Public Health and Human Services seek federal exemptions:

"(1) [Sections 9, 11, 22 through 24, 93, and 95] [37-1-307, 40-1-107, 40-4-105, 40-5-922, 40-5-924, 50-15-403, and 61-5-107] and the bracketed language in [sections 1 through 3, 10, 25, 45, and 89] [40-4-204, 40-5-226, 40-5-901, 40-5-906, 40-5-907, 40-5-923, and 40-6-116] terminate on the date of the suspension if the federal government suspends federal payments to this state for this state's child support enforcement program and for this state's program relating to temporary assistance to needy families because of this state's failure to enact law as required by the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(2) [Sections 9, 11, 22 through 24, 93, and 95] [37-1-307, 40-1-107, 40-4-105, 40-5-922, 40-5-924, 50-15-403, and 61-5-107] and the bracketed language in [sections 1 through 3, 10, 25, 45, and 89] [40-4-204, 40-5-226, 40-5-901, 40-5-906, 40-5-907, 40-5-923, and 40-6-116] terminate on the date that a final decision is rendered in federal court invalidating the child support provisions of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(3) If the director of the department of public health and human services certifies to the governor and the secretary of state in writing that one of the following provisions is no longer required by federal law because of repeal of or amendment to federal statutes that require that provision, the provision terminates on the date the certification takes effect:

(a) [section 9] [40-5-922];

(b) [section 11] [40-5-924];

(c) [sections 22 through 24] [37-1-307, 40-1-107, and 40-4-105];

(d) [section 93] [50-15-403];

(e) [section 95] [61-5-107];

(f) the bracketed provisions in [sections 1 through 3, 10, 25, 45, and 89] [40-4-204, 40-5-226, 40-5-901, 40-5-906, 40-5-907, 40-5-923, and 40-6-116].

(4) If the director of the department of public health and human services certifies to the governor and the secretary of state in writing that the federal government has granted this state an exemption from one of the following provisions, the provision terminates on the date the exemption takes effect:

(a) [section 9] [40-5-922];

(b) [section 11] [40-5-924];

(c) [sections 22 through 24] [37-1-307, 40-1-107, and 40-4-105];

(d) [section 93] [50-15-403, certification filed April 24, 1998];

(e) [section 95] [61-5-107];

(f) the bracketed provisions in [sections 1 through 3, 10, 25, 45, and 89] [40-4-204, 40-5-226, 40-5-901, 40-5-906, 40-5-907, 40-5-923, and 40-6-116].

(5) (a) The department of public health and human services shall do everything reasonably within its power to obtain, as soon as possible, federal government exemptions from the provisions listed in subsection (4).

(b) Because section 395(c) of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) allows a grace period for states to amend their constitutions in order to comply with PRWORA and because the Montana legislature believes that the section of PRWORA prohibiting a jury trial in a paternity proceeding violates Article II, section 26, of the Montana constitution and is therefore rejected, the department of public health and human services shall seek a federal government exemption from the jury trial prohibition in PRWORA as the first exemption it seeks under subsection (5)(a). [This exemption was received on December 8, 1997.]
(6) [Sections 9, 11, 22 through 24, 93, and 95] [37-1-307, 40-1-107, 40-4-105, 40-5-922, 40-5-924, 50-15-403, and 61-5-107] and the bracketed language in [sections 1 through 3, 10, 25, 45, and 89] [40-4-204, 40-5-226, 40-5-901, 40-5-906, 40-5-907, 40-5-923, and 40-6-116] terminate July 1, 1999.

(7) If the bracketed language in [sections 1 through 3, 10, 25, 45, and 89] [40-4-204, 40-5-226, 40-5-901, 40-5-906, 40-5-907, 40-5-923, and 40-6-116] terminates, the code commissioner is instructed to renumber subsections, adjust internal references, and correct grammar and arrangement. "Section 1, Ch. 27, L. 1999, revised this note by deleting references to [section 93], which amended 50-15-403.

1995 Amendment: Chapter 515 in (1) inserted "that weighs at least 350 grams at death or, if the weight is unknown, has reached 20 completed weeks of gestation at death"; and made minor changes in style. Amendment effective January 1, 1996.

Severability: Section 23, Ch. 515, L. 1995, was a severability clause.

1993 Amendment: Chapter 287 in (1), near beginning, substituted "disposition of a dead body or fetus" for "interment" and after "personal data" inserted reference to data on deceased and on parents of fetus; in (2), at beginning, inserted "The person in charge of disposition of the dead body or fetus", substituted "certifying physician" for "physician last in attendance upon the deceased", substituted "for medical certification of" for "or the state medical examiner, who shall certify", after "cause of death deleted "according to his best knowledge and belief", substituted language requiring completion of certification of cause of death for former (2)(b) and (3) that provided alternatives allowing presentation of fetal death certificate to person in attendance or notification to local registrar of attendance or lack of attendance at death (see 1993 Session Law for text), and at end substituted "in the registration area where the death occurred" for "within 3 days after the occurrence"; and made minor changes in style.

1993 Statement of Intent: The statement of intent attached to Ch. 287, L. 1993, provided: "Passage and approval of this bill would require the department of health and environmental sciences [now department of public health and human services] to amend existing rules and possibly to adopt new rules under the authority already delegated under 50-1-202(20) and 50-15-102. The amendments to 50-15-403 replace the current 3-day filing requirement for a death certificate with timeframes established by rule. The legislature intends that these timeframes remain relatively brief but that good cause be recognized when the person in charge of disposition of a dead body is unable to obtain a physician's certification within the set time.

The department shall amend or replace its burial transit permit rule, Rule 16.6.906, Administrative Rules of Montana, to conform with the changes made by 50-15-405. The department may, in replacing this permit with a dead body removal authorization, require any information as to contemplated time, site, and method of disposition as the performance of its vital statistics mission requires."

Administrative Rules

ARM 37.8.801 Death certificate contents.

Collateral References

Health and Environment + 34.

39A C.J.S. Health and Environment § 74.

39 Am. Jur. 2d Health § 106.

MCA 50-15-403, MT ST 50-15-403

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END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 15. VITAL STATISTICS
PART 4. DEATH


(1) Except as provided in subsection (2), a dead body may be removed from the place of death only upon the written authorization or oral authorization, which must be reduced to writing within 24 hours, of the physician in attendance at death or the physician's designee, the advanced practice registered nurse in attendance at death, the coroner having jurisdiction, or a mortician licensed under 37-19-302.

(2) If the death requires inquiry under 46-4-122, the written authorization may only be granted by the coroner having jurisdiction or the coroner's designee or by the state medical examiner if the coroner fails to act. However, when the only reason for inquiry under 46-4-122 is that the body is to be cremated, the coroner may grant oral authorization for cremation of the body, which must be reduced to writing as specified under subsection (1) by the coroner.

(3) The written authorization to move a dead body or, when applicable, to cremate a dead body must be made in quadruplicate on a form provided by the department. The person in charge of disposition of the dead body, the coroner having jurisdiction, and the local registrar must each be provided with and retain a copy of the authorization. A fourth copy may accompany the body to final disposition, as necessary.

(4) A written authorization issued under this section permits removal, transportation, and final disposition of a dead body.


2001 Amendment: Chapter 258 in (1) near end inserted "the advanced practice registered nurse in attendance at death". Amendment effective October 1, 2001.

1995 Amendment: Chapter 515 in second sentence of (2) substituted "cremation" for "removal"; and in (3) inserted "or, when applicable, to cremate a dead body", substituted "quadruplicate" for "triplicate", and inserted sentence providing that a fourth copy may accompany the body to final disposition, as necessary. Amendment effective January 1, 1996.

Severability: Section 23, Ch. 515, L. 1995, was a severability clause.

1993 Amendment: Chapter 287 substituted language concerning authorization to remove a body from place of death for former section that read: "(1) No dead body may be disposed of or removed from a registration district until a permit for disposition or removal has been issued by the local registrar.

(2) No permit may be issued until a death certificate, fetal death certificate, or notice of delay as required in subsection (3) of this section has been filed with the local registrar.

(3) If the cause of death or fetal death cannot be determined within 3 days after the occurrence, the attending physician, coroner, or medical examiner shall give the local registrar written notice of the reason for delay so that a permit may be issued for disposition of the body."

1993 Statement of Intent: The statement of intent attached to Ch. 287, L. 1993, provided: "Passage and approval of this bill would require the department of health and environmental sciences [now department of public health and human services] to amend existing rules and possibly to adopt new rules under the authority already delegated under 50-1-202(20) and 50-15-102. The amendments to 50-15-403 replace the current 3-day filing requirement for a death certificate with timeframes established by rule. The legislature intends that these timeframes remain relatively brief but that good cause be recognized when the person in charge of disposition of a dead body is unable to obtain a physician's certification within the set time.

The department shall amend or replace its burial transit permit rule, Rule 16.6.906, Administrative Rules of Montana, to conform with the changes made by 50-15-405. The department may, in replacing this
permit with a dead body removal authorization, require any information as to contemplated time, site, and method of disposition as the performance of its vital statistics mission requires."

**Administrative Rules**

- [ARM 37.8.802](#) Fetal death certificate.
- [ARM 37.8.808](#) Dead body removal authorization.

**Collateral References**

- Health and Environment + 35.

MCA 50-15-405, **MT ST 50-15-405**

Current through the 2005 Regular Session of the 59th Legislature
As used in this part, the following definitions apply:

(1) (a) "Data" means written reports, notes, or records or oral reports or proceedings created by or at the request of a utilization review, peer review, medical ethics review, quality assurance, or quality improvement committee of a health care facility that are used exclusively in connection with quality assessment or improvement activities, including the professional training, supervision, or discipline of a medical practitioner by a health care facility.

(b) The term does not include:

(i) incident reports or occurrence reports; or

(ii) health care information that is used in whole or in part to make decisions about an individual who is the subject of the health care information.

(2) "Health care facility" has the meaning provided in 50-5-101.

(3) (a) "Incident reports" or "occurrence reports" means a written business record of a health care facility, created in response to an untoward event, such as a patient injury, adverse outcome, or interventional error, for the purpose of ensuring a prompt evaluation of the event.

(b) The terms do not include any subsequent evaluation of the event in response to an incident report or occurrence report by a utilization review, peer review, medical ethics review, quality assurance, or quality improvement committee.

(4) "Medical practitioner" means an individual licensed by the state of Montana to engage in the practice of medicine, osteopathy, podiatry, optometry, or a nursing specialty described in 37-8-202 or licensed as a physician assistant pursuant to 37-20-203.

History: En. Sec. 4, Ch. 104, L. 1969; R.C.M. 1947, 69-6304; amd. Sec. 1, Ch. 359, L. 2001; amd. Sec. 5, Ch. 396, L. 2003; amd. Sec. 124, Ch. 467, L. 2005; amd. Sec. 25, Ch. 519, L. 2005.
C
MCA 50-16-205, MT ST 50-16-205

MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 16. HEALTH CARE INFORMATION
PART 2. PROFESSIONAL REVIEW COMMITTEES

50-16-205. Data confidential -- inadmissible in judicial proceedings

All data is confidential and is not discoverable or admissible in evidence in any judicial proceeding. However, this section does not affect the discoverability or admissibility in evidence of health care information that is not data as defined in 50-16-201.


<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

2001 Amendment: Chapter 359 in first sentence inserted "discoverable or"; in second sentence inserted "discoverability or" and at end substituted "health care information that is not data as defined in 50-16-201" for "records dealing with the patient's hospital care and treatment"; and made minor changes in style. Amendment effective April 23, 2001.

Cross-References

Montana Rules of Evidence, Title 26, ch. 10.

Case Notes

Documents Dealing With Patient Care and Treatment Discoverable Under Hospital Peer Review Statutes -- Data Protected From Disclosure: The net effect of the hospital peer review statutes is that health care information belongs to both the patient and the hospital, while data is a matter of an internal administrative function. To the extent that documents over which a hospital seeks protection are relevant to a patient's care and treatment, they are discoverable, but to the extent that documents are data in connection with the professional training, supervision, or discipline of the hospital medical staff, they are not discoverable. The right of confidentiality created under this section is subject to the patient's right of access to records concerning that patient's own hospital care and treatment, consistent with the Uniform Health Care Information Act, which also provides that a personal representative of a deceased patient may exercise all the deceased patient's rights, including the right of the deceased's estate to examine or copy all of the deceased patient's health care information. Huether v. District Court, 2000 MT 158, 300 M 212, 4 P3d 1193, 57 St. Rep. 647 (2000), distinguishing Sistok v. Kalispell Regional Hosp., 251 M 38, 823 P2d 251 (1991), and overruling Sistok to the extent that that case may not be read to apply to a hospital patient seeking disclosure of information concerning that patient's care or treatment. (See 2001 amendment.)

MCA 50-16-205, MT ST 50-16-205

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 16. HEALTH CARE INFORMATION
PART 5. UNIFORM HEALTH CARE INFORMATION

50-16-502. Legislative findings

The legislature finds that:

(1) health care information is personal and sensitive information that if improperly used or released may do significant harm to a patient's interests in privacy and health care or other interests;

(2) patients need access to their own health care information as a matter of fairness, to enable them to make informed decisions about their health care and to correct inaccurate or incomplete information about themselves;

(3) in order to retain the full trust and confidence of patients, health care providers have an interest in ensuring that health care information is not improperly disclosed and in having clear and certain rules for the disclosure of health care information;

(4) persons other than health care providers obtain, use, and disclose health record information in many different contexts and for many different purposes. It is the public policy of this state that a patient's interest in the proper use and disclosure of the patient's health care information survives even when the information is held by persons other than health care providers.

(5) the movement of patients and their health care information across state lines, access to and exchange of health care information from automated data banks, and the emergence of multistate health care providers creates a compelling need for uniform law, rules, and procedures governing the use and disclosure of health care information.

(6) the enactment of federal health care privacy legislation and the adoption of rules pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d, et seq., require health care providers subject to that legislation to provide significant privacy protection for health care information and the provisions of this part are no longer necessary for those health care providers; and

(7) because the provisions of HIPAA do not apply to some health care providers, it is important that these health care providers continue to adhere to this part.

History: En. Sec. 2, Ch. 632, L. 1987; amd. Sec. 6, Ch. 396, L. 2003.

NOTES, REFERENCES, AND ANNOTATIONS

Official Comments

The inclusion of a statement of legislative findings is a common practice in privacy legislation. These findings aid agency officials, courts, and the public in identifying and properly applying the Act's purposes. The Conference's Uniform Information Practices Code contains a statement of "General Provisions" which sets forth the purposes to be served by the Information Practices Code.

The first statement recognizes the extraordinary sensitivity of health-care information. The second expresses the Act's view that patients should have access to their own health-care information and an opportunity to correct inaccurate or incomplete information. The Act seeks to give patients more control over their health-care information by giving them a right to see and copy their own records and to correct and amend their records when these records are in the hands of health-care providers.

The third statement expresses the view that health-care providers have an interest in assuring the confidentiality of health-care information and in being able to rely upon clear and certain rules to govern disclosure decisions. In this regard the Act permits patients to approve or disapprove disclosures by health-care providers to third parties in most instances. Moreover, the Act seeks to restrict and regulate the flow of health-care information to third parties by carefully limiting disclosures that can be made without patient consent; by restricting the acquisition of health-care information by compulsory process; and by imposing security requirements on health-care providers maintaining such data.

The fourth statement makes the point that many nonhealth-care providers obtain, use, and disclose health-care information for innumerable nonhealth-care purposes. It is the public policy of the state that a patient has an interest in the proper use and
disclosure of the patient's health-care information even when the information is held by nonhealth-care providers. The purpose of this statement is to recognize that such rights exist as a matter of case law and other expressions of public policy and to assure that enactment of the Act—notwithstanding its general limitation to health-care providers—does not undercut health-record privacy rights that may exist under other law and in other contexts.

There are two reasons why the Act does not attempt to regulate the use or redisclosure of health-care information once such information is held by nonhealth-care providers (except in those limited circumstances set forth in Article II [50-16-525 through 50-16-530, 50-16-535, and 50-16-536] where a health-care provider makes health-care information available to third parties without the patient's consent and in order to meet the provider's needs or interests). First, the expectations that a patient and society can rightfully have concerning the use and disclosure of health-care information must necessarily change when health-care information is held by nonhealth-care providers. The type of relationship that nonhealth-care providers have with patients is inevitably different than the relationship that health-care providers have with patients. The interests that will be advanced or deterred by confidentiality are different; the needs of the nonhealth-care providers to use and disclose the information are different; and the threat to patient privacy interests is different. These issues are complex, and require different responses, depending on the identity of the particular holder of the record and the reasons for which the records are held.

Second, in recognition of these differing interests and needs Congress and state legislatures have already adopted, or are well along in the process of adopting, statutes that regulate the handling of personal information, including health-care information, when held outside of the health-care relationship. For example, the Fair Credit Reporting Act regulates the handling of health-care information by consumer reporting agencies. The Privacy Act of 1974 regulates the handling of health-care information by federal agencies. Over a dozen states have adopted statutes which regulate the handling of health-care information by state agencies. A model privacy protection act, promulgated by the National Association of Insurance Commissioners, and thus far adopted in over ten states, addresses the handling of health-care information by insurance carriers. Several states have adopted statutes which regulate the handling of health-care information by private employers.

These legislative developments indicate as an empirical matter that a health-care information statute should not cover the handling of health-care information by nonhealth-care providers. As a conceptual matter a health-care information statute should not attempt to cover health-care information in other record-keeping settings because the expectations, interests, needs, and threats posed by the use and disclosure of health-care information in these different record-keeping relationships vary so significantly.

No doubt for these reasons, virtually every record-keeping and privacy statute that has been adopted, including the Conference's Uniform Information Practices Code, regulates personal information according to the type of record-keeper holding the information, and not according to the type of personal information being held. In taking this approach Congress, state legislatures, and other legislative authors are acting in a manner that is consistent with the recommendations of the Privacy Protection Study Commission.

Notwithstanding all this, the extraordinarily sensitive nature of health-care information makes it appropriate to provide, as statement four does, that it is the public policy of the state that a patient retains his privacy interest in health-care information even after the information leaves the provider-patient relationship.

The fifth and final statement in the Findings section explains that a uniform law is necessary due to the movement of patients and their health-care information across state lines; the use of automated information systems; and the emergence of multi-state health-care providers.

Certainly, it is increasingly common for patients to have health-care information created in one state but used in another state. Given the mobility of patients, and the patients' use of providers located in different states, it is important for patients to be able to rely on uniform rules for patient access and confidentiality. Moreover, health-care information is increasingly maintained and communicated via automated information systems. The effective operation of these systems and their operation in a manner protective of patient interest is advanced by uniform confidentiality standards.

Furthermore, health care increasingly is provided
by many different types of providers. In the early part of this century roughly 85 percent of all health professionals were physicians. Today physicians make up only about five percent of the total. Dilemma, A Report of the National Commission on the Confidentiality of Health Records (1977), at p. 2. Thus, patients' physicians' ethical tradition of confidentiality plays a diminishing role in assuring health-record privacy.

Moreover, not only are health-care occupations changing, so too is the corporate status of health-care providers. Increasingly, health care is provided by national corporations with health-care operations in many different states. Some of these corporations have begun to centralize their record-keeping operations. As a result of these changes in the health-care industry, it is of growing importance that providers be able to rely upon uniform confidentiality standards.

Compiler's Comments

2003 Amendment: Chapter 396 inserted (6) and (7) finding that the enactment of federal law has made the provisions of this part unnecessary for certain health care providers but that the legislature intends this part to apply to health care providers to whom the federal law does not apply; and made minor changes in style. Amendment effective April 18, 2003.

Source: This section is derived from section 1-101 of the Uniform Health-Care Information Act as adopted by the National Conference of Commissioners on Uniform State Laws.

Case Notes

Revealing Limited Medical Information During Police Interview Not Considered Waiver of Constitutional Right to Confidentiality in Medical Records -- Voluntary Medical Information Outside Scope of Fruit of Poisonous Tree Doctrine -- Adequate Probable Cause for Investigative Subpoena of Medical Records: Bilant was involved in a three-car accident and was subsequently arrested for DUI and a seat belt violation. During an interview following the arrest, Bilant revealed to an officer that he had taken pain medication on the day of the accident. The officer called Bilant's health care provider for confirmation, and the provider confirmed that Bilant had a prescription for a drug similar to the pain medication that he mentioned. The officer then procured an investigative subpoena regarding documentation on all prescriptions issued to Bilant, including any advisory warnings, and the provider sent Bilant's entire medical file. Bilant contended that the state violated both his constitutional right to privacy and the statutory protections of 50-16-535. The state maintained that Bilant waived his claim of confidentiality in his medical information when he voluntarily revealed his use of pain medication to the officer. The Supreme Court agreed with Bilant. Medical records are quintessentially private and deserve the utmost constitutional protection. None of the statutory prerequisites for disclosure of the medical records were met. In deciding to reveal limited medical information in a police interview, Bilant did not forfeit his constitutional right to subsequently claim confidentiality in his medical records. The officer conducted an illegal search in seeking the constitutionally protected private medical information without probable cause and the benefit of an investigative subpoena under 46-4-301, and the information gleaned from the telephone call should have been suppressed. Bilant then contended that the use of the illegally obtained information formed an improper basis for the investigative subpoena and that the results of the subpoena should also have been suppressed pursuant to the fruit of the poisonous tree doctrine, which forbids the use of evidence that comes to light as the result of an initially illegal act. However, on this point, the Supreme Court disagreed with Bilant. One exception to the doctrine is that the derivative evidence is admissible if it is obtained from an independent source. Here, Bilant himself provided the source by giving voluntary medical information from other than the illegal telephone inquiry. The Supreme Court recognized that an investigative subpoena seeking constitutionally protected medical information requires greater justification for state access than the administration of justice rationale used to obtain public information under 46-4-301, so in reviewing the probable cause basis for constitutionally protected material, the court excised the illegal evidence from the application and reviewed the remaining information de novo to determine whether probable cause existed for issuing the subpoena. In this case, even when the information subject to suppression was excised, the remaining evidence established probable cause that a DUI was committed and underscored a compelling state interest in medical records related to prescription medicines in order to confirm Bilant's initial admission to the officer. Thus, the subpoena was issued in accordance with the statutory requirements for constitutionally protected medical records, and Bilant's conviction was affirmed. St. v. Bilant, 2001
MCA 50-16-502, MT ST 50-16-502


Collateral References

Hospitals + 5; Physicians and Surgeons + 2, 12, 15(8), (9); Torts + 8.5(1), (2).

41 C.J.S. Hospitals § 7; 70 C.J.S. Physicians, Surgeons, and Other Health-Care Providers § § 7, 58 through 61; 77 C.J.S. Right of Privacy and Publicity § 1, et seq.

MCA 50-16-502, MT ST 50-16-502

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
The provisions of this part apply only to a health care provider that is not subject to the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d, et seq., and administrative rules adopted in connection with HIPAA.

History: En. Sec. 8, Ch. 396, L. 2003.

Compiler's Comments

Effective Date: Section 26, Ch. 396, L. 2003, provided: "[This act] is effective on passage and approval." Approved April 18, 2003.
(1) A health care provider shall retain each authorization or revocation in conjunction with any health care information from which disclosures are made.

(2) Except for authorizations to provide information to third-party health care payors, an authorization may not permit the release of health care information relating to health care that the patient receives more than 6 months after the authorization was signed.

(3) Health care information disclosed under an authorization is otherwise subject to this part. An authorization becomes invalid after the expiration date contained in the authorization, which may not exceed 30 months. If the authorization does not contain an expiration date, it expires 6 months after it is signed.

(4) Notwithstanding subsections (2) and (3), a signed claim for workers' compensation or occupational disease benefits authorizes disclosure to the workers' compensation insurer, as defined in 39-71-116, or to the agent of a workers' compensation insurer by the health care provider. The disclosure authorized by this subsection authorizes the physician or other health care provider to disclose or release only information relevant to the claimant's condition. Health care information relevant to the claimant's condition may include past history of the complaints of or the treatment of a condition that is similar to that presented in the claim, conditions for which benefits are subsequently claimed, other conditions related to the same body part, or conditions that may affect recovery. A release of information related to workers' compensation must be consistent with the provisions of this subsection. Authorization under this section is effective only as long as the claimant is claiming benefits. This subsection may not be construed to restrict the scope of discovery or disclosure of health care information as allowed under the Montana Rules of Civil Procedure, by the workers' compensation court, or as otherwise provided by law.

(5) A signed claim for workers' compensation or occupational disease benefits or a signed release authorizes a workers' compensation insurer, as defined in 39-71-116, or the agent of the workers' compensation insurer to communicate with a physician or other health care provider about relevant health care information, as authorized in subsection (4), by telephone, letter, electronic communication, in person, or by other means, about a claim and to receive from the physician or health care provider the information authorized in subsection (4) without prior notice to the injured employee, to the employee's authorized representative or agent, or in the case of death, to the employee's personal representative or any person with a right or claim to compensation for the injury or death.

History: En. Sec. 7, Ch. 632, L. 1987; amd. Sec. 13, Ch. 333, L. 1989; amd. Sec. 1, Ch. 480, L. 1999; amd. Sec. 5, Ch. 464, L. 2003.

NOTES, REFERENCES, AND ANNOTATIONS

Official Comments

Subsection (e) [subsection (1) of this section] requires health-care providers to maintain authorizations in conjunction with the patient's health-care information.

Subsection (f) [subsection (2) of this section] limits authorizations to information that already exists or will exist within six months, and prohibits general releases for any information that may be thereafter created. However, an exception is made for authorizations given to third-party payors, including insurance companies and employers who are self-insurers, in order to avoid disrupting and delaying patient reimbursements. It should be noted that Article VI [50-16-521 and 50-16-522] provides for a similar exception where under state law, a second individual is authorized to "stand in the shoes" of a patient who may be incompetent or who has provided a general power of attorney; in such cases no purpose would be served by requiring the guardian or attorney to constantly return to the patient to seek information.

Subsection (g) [subsection (3) of this section] provides a "grandfather" clause for authorizations in

effect prior to the passage of this Act. It could create needless confusion to simply nullify those authorizations even though they do not meet the technical requirements of Section 2-102 [50-16-526]. Therefore, any authorization in effect prior to the passage of this Act will remain in effect for a period of 30 months unless an earlier date is specified or the patient elects to revoke the authorization by written notice pursuant to Section 2-103 [50-16-528]. Except for the technical requirements of the authorization, health-care information created prior to the effective date of this Act is fully subject to its requirements.

The subsection also provides for a 30-month cap on the length of authorizations signed after the effective date of the Act, although the patient would of course be free to specify a shorter period. The Privacy Protection Study Commission recommended a one-year authorization period; however, it was felt that such a short limit could create logistical problems for patients and providers without an accompanying increase in patient protection. The 30-month period was chosen to permit life insurers access to patient records, pursuant to a disclosure authorization, during the two-year contestibility period found in most life insurance policies, and to provide them with a short grace period thereafter to initiate legal action.

The time limits in subsections (f) and (g) [subsection (2) and (3) of this section] must be read together to determine the validity of a particular authorization. For 30 months after an authorization is signed, the holder may obtain access to any records in existence on the date the authorization was signed, or which were created within six months thereafter. Health-care information created more than six months after an authorization is signed cannot be obtained without a new authorization.

Compiler's Comments


Applicability: Section 6(4), Ch. 464, L. 2003, provided that this section applies retroactively, within the meaning of 1-2-109, to injuries occurring before April 21, 2003.

1999 Amendment: Chapter 480 in (3) deleted former first sentence that read: "An authorization in effect on October 1, 1987, remains valid for 30 months after October 1, 1987, unless an earlier date is specified or it is revoked under 50-16-528" and in second sentence at beginning after "An authorization" deleted "written after October 1, 1987"; in (4) near middle of second sentence after "subsection" substituted "authorizes the physician or other health care provider to disclose or release only" for "relates only to", inserted third and fourth sentences outlining relevant health care information, and inserted sixth sentence limiting applicability of the subsection with regard to discovery or disclosure of health care information allowed by law; and made minor changes in style. Amendment effective April 27, 1999.

1989 Amendment: Inserted (4) allowing disclosure of health care information by health care provider to insurers of information relating to claimant's condition so long as claimant is receiving benefits. Amendment effective March 27, 1989.

Retroactive Applicability: Section 16, Ch. 333, L. 1989, provided that this section applies retroactively, within the meaning of 1-2-109, to all requests for health care information in workers' compensation claims.

Source: This section is derived from subsections (e) through (g) of section 2-102 of the Uniform Health-Care Information Act as adopted by the National Conference of Commissioners on Uniform State Laws.

Collateral References

Hospitals + 5; Physicians and Surgeons + 12, 15(8), (9); Torts + 8.5(1), (2).

41 C.J.S. Hospitals § 7; 70 C.J.S. Physicians, Surgeons, and Other Health-Care Providers § 58 through 61, 70; 77 C.J.S. Right of Privacy and Publicity § 1, et seq.

MCA 50-16-527, MT ST 50-16-527

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT

A health care provider may disclose health care information about a patient without the patient's authorization, to the extent a recipient needs to know the information, if the disclosure is:

(1) to a person who is providing health care to the patient;

(2) to any other person who requires health care information for health care education; to provide planning, quality assurance, peer review, or administrative, legal, financial, or actuarial services to the health care provider; for assisting the health care provider in the delivery of health care; or to a third-party health care payor who requires health care information and if the health care provider reasonably believes that the person will:

(a) not use or disclose the health care information for any other purpose; and

(b) take appropriate steps to protect the health care information;

(3) to any other health care provider who has previously provided health care to the patient, to the extent necessary to provide health care to the patient, unless the patient has instructed the health care provider not to make the disclosure;

(4) to immediate family members of the patient or any other individual with whom the patient is known to have a close personal relationship, if made in accordance with the laws of the state and good medical or other professional practice, unless the patient has instructed the health care provider not to make the disclosure;

(5) to a health care provider who is the successor in interest to the health care provider maintaining the health care information;

(6) for use in a research project that an institutional review board has determined:

(a) is of sufficient importance to outweigh the intrusion into the privacy of the patient that would result from the disclosure;

(b) is impracticable without the use or disclosure of the health care information in individually identifiable form;

(c) contains reasonable safeguards to protect the information from improper disclosure;

(d) contains reasonable safeguards to protect against directly or indirectly identifying any patient in any report of the research project; and

(e) contains procedures to remove or destroy at the earliest opportunity, consistent with the purposes of the project, information that would enable the patient to be identified, unless an institutional review board authorizes retention of identifying information for purposes of another research project;

(7) to a person who obtains information for purposes of an audit, if that person agrees in writing to:

(a) remove or destroy, at the earliest opportunity consistent with the purpose of the audit, information that would enable the patient to be identified; and

(b) not disclose the information further, except to accomplish the audit or to report unlawful or improper conduct involving fraud in payment for health care by a health care provider or patient or other unlawful conduct by a health care provider;

(8) to an official of a penal or other custodial institution in which the patient is detained; and

(9) to any contact, as defined in 50-16-1003, if the health care provider reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of the contact or any other individual.

History: En. Sec. 9, Ch. 632, L. 1987; amd. Sec. 3, Ch. 657, L. 1989; amd. Sec. 6, Ch. 544, L. 1991.
Official Comments

Subsection (a) [this section] enumerates certain circumstances under which disclosure can be made without patient consent. Disclosure under this subsection is on a need-to-know basis only.

Paragraph (a)(1) [subsection (1) of this section] permits consultation within a health-care facility and with other health-care providers who are currently treating a patient. Such disclosures are often necessary to permit proper treatment and are of course limited by the general "need-to-know" restriction.

Paragraph (a)(2) [subsection (2) of this section] allows disclosure to persons who are not themselves health-care providers for planning, financial, administrative, or legal purposes. Thus billing services, outside laboratories, independent x-ray facilities, and other outside persons performing functions on behalf of the health-care facility can obtain records without patient authorization. Under this subsection records might be used by or disclosed to staff doctors, research fellows, student doctors and nurses, hospital accountants, and the hospital legal staff. Similarly, records would also be available to an attorney or insurance company acting on behalf of a health-care facility. Although subject to the need-to-know limitation, this paragraph adds restrictions on use and redisclosure of records by nonemployees performing services for a facility. Health-care providers must be satisfied that recipients have agreed to refrain from using the information for any purpose other than for the reason it was disclosed, and to take appropriate steps to protect its confidentiality. Thus, this provision, like other provisions in this Act which authorize nonconsensual disclosures, imposes restrictions on redisclosure. Such restrictions are appropriate and conceptually consistent with other provisions in the Act in that when disclosure is authorized by the patient the Act leaves the question of redisclosure to be worked out by the patient and the recipient or by other law. However, when the disclosure is not authorized by a patient, limits on redisclosure are appropriate because the patient does not have a basis for imposing redisclosure limitations on the recipient.

Paragraph (a)(3) [subsection (3) of this section] permits a health-care provider to consult with other health-care providers who have previously treated the patient. Under this provision, for example, a specialist might consult with the patient's general practitioner to help establish a diagnosis or recommended course of treatment. The patient is given the option of prohibiting such disclosures.

Paragraph (a)(4) [not adopted in Montana] permits a health-care provider to disclose information from a patient's record where the health-care provider has reason to believe that disclosure will avoid or minimize imminent danger to the health or safety of the patient or any other individual. Once it is apparent that an individual's health or safety is in imminent jeopardy, privacy concerns can become secondary. In some instances, such as after a serious accident, a patient may be unconscious and unable to consent to the release of information. This subsection would thus permit disclosure to a physician for purposes of emergency treatment. In other cases, such as where the patient is threatening the lives of hostages, the patient will obviously refuse to authorize disclosure. In such cases, immediate access to health-record information by appropriate personnel may be vital. For example, if a psychotic patient tells a physician he will kill another person as soon as he leaves the offices of the physician, that physician should disclose this threat of imminent danger to the threatened person or to the authorities. See Tarasoff v. Regents of the University of California, 17 Cal.3d 425, 551 P.2d 334, 131 Cal.Rptr. 14 (1976) (physician has duty to exercise reasonable care to protect third persons who may be injured by a patient's actions; thus physician may be liable for failure to warn victim of patient's violent threats).

Paragraph (a)(5) [subsection (4) of this section] permits a disclosure in those instances where it is generally assumed, and not formally required, to immediate family. For example, if a patient is in a coma or is in intensive care after surgery, generally the patient's family is informed of the patient's condition, even if an authorization was not completed beforehand.

There are two restrictions on such disclosures. First, they must be in accordance with good health-care practices. This means that the patient's health-care provider must believe that such a disclosure is appropriate under the circumstances of each individual case. Secondly, the patient may prohibit any disclosure by so informing the health-care provider.

Even where a relative objects to disclosure to another relative, the person seeking information still has the option of going to court to seek release under Section 2-105(a)(9) [50-16-535(9)]. This might be necessary, for example, if a mother denies her
daughter access to records concerning the mother's use of DES or other drugs that could affect descendants.

Paragraph (a)(6) [subsection (5) of this section] is intended to deal with those situations in which a health-care facility or health-care practice is sold. Such sales normally include a transfer of existing patient files. This practice would be permitted to continue, without the need to obtain consent from each individual patient.

Paragraph (a)(7) [subsection (6) of this section] permits disclosure to health researchers provided that the research project has first been reviewed and approved by an institutional review board (IRB). IRB's established pursuant to Section 474 of the Public Health Service Act or other federal or state law already review all medical research subject to FDA approval to determine, inter alia, whether patient confidentiality has been sufficiently protected. See 21 C.F.R. § 56.111(7). This Act extends the concept of the IRB to all medical research utilizing individually identifiable health-record information and instructs the review board to make a number of determinations before it can approve the release of identifiable health-record information to a researcher. This requires a decision that the research is sufficiently important to outweigh the patient's privacy interests; is impractical to conduct without health-record information in individually identifiable form; and that the research plan contains adequate safeguards to protect against disclosure of patient identities and other unauthorized redisclosure. While paragraph (a)(7)(v) [subsection (6)(e) of this section] permits a researcher to retain health-record information indefinitely if there is a need to do so, it is intended that the researcher discuss the need to retain individually identifiable information with the IRB before undertaking the project.

Recognizing the importance of medical research to society, the subsection authorizes researchers to redisclose health-record information under certain carefully circumscribed conditions. For example, this provision will permit routine disclosure of health-record information to "registries" established to monitor various diseases such as cancer. Before any such disclosure can be made, however, the registry, like any other research project, would have to be reviewed by an institutional review board. Registries, which in large measure exist to provide a database for other research, would also be able to redisclose health-record information, provided that the redisclosure is first approved by an institutional review board.

There are many other situations in which redisclosure of health-record information to other researchers may be necessary. For example, when results of a medical study are published and then reviewed by other researchers and scholars, questions about the conduct of the research or adequacy of the data may arise. If the data may not be redisclosed, there may be no way to verify its accuracy. Further, some studies require that medical records be checked many years after treatment. In a recent example, the link between vaginal cancer and the drug DES was established only after researchers were able to check the records of the victims' mothers, and learned that the mothers had taken DES 20 years before. Indeed, the term "research project" should be broadly construed, and may encompass a series of linked projects. The need to retain information or redisclose it, and the adequacy of the security safeguards should be determined by the IRB on a case-by-case basis.

At the same time, this subparagraph [subsection (6) of this section] prevents researchers from becoming information resources for law enforcement personnel or for others who might be curious about such data. Health-care providers and patients must be confident that information supplied to researchers will not be used to make decisions directly affecting patients. Thus, the Act permits redisclosure only to other researchers in conformity with a researcher's plan approved by an appropriate institutional review board.

Paragraph (a)(8) [subsection (7) of this section] is intended to strike a balance between the individual's right of privacy and society's interest in controlling and managing health-care programs, including third-party payment programs. It permits disclosure for purposes of an audit, provided that the auditor not publicly release patient-identifiable information, unless it is essential to do so and, in any event, removes or destroys such information from any copies of the original material that are retained by the auditor at the earliest opportunity consistent with the purposes of the audit.

Paragraph (a)(9) [subsection (8) of this section] permits a health-care provider to release patient records to a prison or other custodial facility while an individual is in custody, regardless of whether the health care was provided by the custodial facility or any other health-care facility. Once an individual is released from custody, the individual will have all of the rights accorded by this Act, regardless of whether
the records were compiled while the individual was in custody.

**Compiler's Comments**

**1991 Amendment:** Inserted (9) concerning disclosure to avoid or minimize danger. Amendment effective July 1, 1991.

**Severability:** Section 8, Ch. 544, L. 1991, was a severability clause.

**1989 Amendment:** In (2), after "delivery of health care", inserted "or to a third-party health care payor who requires health care information"; and made minor change in phraseology.

**Source:** This section is derived from subsection (a) of section 2-104 of the Uniform Health-Care Information Act as adopted by the National Conference of Commissioners on Uniform State Laws.

**Cross-References**

- Duty of mental health professionals to warn of violent patients, 27-1-1102.
- Nonliability for peer review, 37-2-201.
- Pharmacists not liable for peer review, 37-7-1101.
- Release of information by physician concerning minor, 41-1-403.
- Maintenance and confidentiality of records concerning persons with developmental disabilities, 53-20-161.
- Confidentiality of records concerning mental illness, 53-21-166.

**Attorney General's Opinions**

**Conditions for Release of Information About HIV Test Subject -- Imminent Danger to Health or Safety:**

In reconciling the apparent conflict in the provision of medical information as contained in the Uniform Health Care Information Act and the AIDS Prevention Act, the Attorney General determined that a health care provider may release health care information about the subject of an HIV-related test, including the identity of the subject, to a contact, as defined in 50-16-1003, without the subject's authorization, only when the health care provider reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of the contact or other individual. 44 A.G. Op. 37 (1992).

**Collateral References**

- Hospitals + 5; Physicians and Surgeons + 2, 12, 15(8), (9); Torts + 8.5(1), (2).
- 41 C.J.S. Hospitals § § 13, 15; 70 C.J.S. Physicians, Surgeons, and Other Health-Care Providers § § 7, 58 through 61, 70; 77 C.J.S. Right of Privacy and Publicity § 1, et seq.

MCA 50-16-529, **MT ST 50-16-529**

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
(1) Health care information may not be disclosed by a health care provider pursuant to compulsory legal process or discovery in any judicial, legislative, or administrative proceeding unless:

(a) the patient has authorized in writing the release of the health care information in response to compulsory process or a discovery request;

(b) the patient has waived the right to claim confidentiality for the health care information sought;

(c) the patient is a party to the proceeding and has placed the patient's physical or mental condition in issue;

(d) the patient's physical or mental condition is relevant to the execution or witnessing of a will or other document;

(e) the physical or mental condition of a deceased patient is placed in issue by any person claiming or defending through or as a beneficiary of the patient;

(f) a patient's health care information is to be used in the patient's commitment proceeding;

(g) the health care information is for use in any law enforcement proceeding or investigation in which a health care provider is the subject or a party, except that health care information so obtained may not be used in any proceeding against the patient unless the matter relates to payment for the patient's health care or unless authorized under subsection (1)(j);

(h) the health care information is relevant to a proceeding brought under 50-16-551 through 50-16-553;

(i) the health care information is relevant to a proceeding brought under Title 41, chapter 3;

(j) a court has determined that particular health care information is subject to compulsory legal process or discovery because the party seeking the information has demonstrated that there is a compelling state interest that outweighs the patient's privacy interest; or

(k) the health care information is requested pursuant to an investigative subpoena issued under 46-4-301 or a similar federal law.

(2) This part does not authorize the disclosure of health care information by compulsory legal process or discovery in any judicial, legislative, or administrative proceeding in which disclosure is otherwise prohibited by law.

History: En. Sec. 11, Ch. 632, L. 1987; amd. Sec. 4, Ch. 657, L. 1989; amd. Sec. 9, Ch. 396, L. 2003; amd. Sec. 24, Ch. 504, L. 2003.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, ANDANNOTATIONS

Official Comments

Many of the protections contained in this Act would be of little value if government agencies or others were free to obtain health-care information from health-care providers through the unconditional use of compulsory process or discovery. A hospital or other health-care provider faced with a subpoena, search warrant, or discovery request is now generally required to turn over sensitive health-record information about a patient before the patient who is the subject of the record even knows the information has been requested. See Gellman, supra, at 287-292; Note, Privacy in Personal Medical Information: A Diagnosis, U. Fla. L. Rev. 394, 396-400 (1981). And, under current law in most jurisdictions, since the patient does not have possession of the documents sought through compulsory process or discovery, there is little he can do to contest their release, even when he does have knowledge. Cf. United States v. Miller, 425 U.S. 435 (1976) (customer has no right to challenge subpoena issued to a financial institution to produce the customer's records, which were in the possession of the financial institution).

There are several different ways that this problem can be addressed. The traditional physician-patient privilege, which exists in some form in nearly every state, precludes testimony by a health-care provider about a patient's health-care information.
See Gellman, supra, at 272-274. The privilege does not, however, shield health-care information from disclosure pursuant to legal process, and the recipient is free to use information so obtained to pursue investigatory leads. See, e.g., Idaho Code § 9-203 (1982) (physician-patient privilege applies only where physician is subject to examination as a witness in litigation). Thus, the privilege, while it does protect a patient from some potential adverse consequences, does little to protect a patient's privacy interests.

The Federal Right to Financial Privacy Act attempted to address this problem for bank records by requiring the notification of the subject of records sought through compulsory process before his or her records were released. See 12 U.S.C. §§ 3401-3422 (1982). The subject was then given the right to go to court to bring an action to block release of the records. This approach has not worked well in practice. Few individuals have the knowledge or resources necessary to pursue a legal action, and, if adopted here, it would place a considerable burden on the patient. Further, such actions could potentially clog the courts and are cumbersome, requiring a number of expedited procedures and exceptions.

Section 2-105 [50-16-536 and this section] embodies a different approach, which has already been adopted by some states. See, e.g., Cal.Evid.Code § 994 (West 1980); Mont.Code Ann. § 50-16-314 (1980) [repealed 1987]; R.I.Gen.Laws § 5-37.3-6 (1980). Under this section, production of health-care information could not be compelled in any type of proceeding. It thus extends a physician-patient type privilege to encompass investigations and discovery. In a few states, this Act would create, for the first time, a comprehensive physician-patient type privilege. The general prohibition on the use of compulsory process or discovery in investigatory proceedings represents a major change in policy, modifying long-standing state privilege rules.

This general restriction on compulsory process and discovery does not apply where one of the exceptions contained in subsection (a) [this section] apply. Subsection (a) [this section] authorizes the use of discovery and compulsory process in nine specified situations. These situations generally include cases where a patient has consented to release of information, litigation, such as malpractice cases, where the patient is a party to a lawsuit, litigation involving a will or a deceased patient, health-care information obtained pursuant to a court-ordered examination, health-care fraud investigations, or pursuant to court order in cases where the interest in access outweighs the patient's privacy interest. In such cases, a patient may assert any of the usual procedural rules or defenses that existed prior to the passage of this Act. Nothing in this Act is intended to reduce current patient rights or to provide any new grant of subpoena authority.

It is important to note that this section in no way supersedes or modifies a state's rules of evidence. While the section does provide a new threshold test that must be met before health-care information is subject to discovery or subpoena, that test is an easier one to meet than the requirements of the rules of evidence. Thus, once health-care information has been discovered under this section, the normal rules of evidence govern its use at trial. There should be no situation in which health-care information would be admissible at trial, but shielded from discovery by this section; on the other hand, it may often be the case that discoverable health-care information will prove inadmissible at trial.

Subsection (a)(2) [subsection (2) of this section] is intended to permit discovery or compulsory process where the patient has waived confidentiality. It would make little sense, for example, to protect a patient's records from compulsory process where the patient has already granted a newspaper interview about his health condition.

Subsection (a)(3) [subsection (3) of this section] permits the use of a patient's health-care information where the patient is a party to a lawsuit and has placed his health at issue. This section should be narrowly interpreted, however. If a patient has placed his physical condition at issue, there should not be automatic access to his mental-health records. Where broader access is desired, or where the patient is a witness or a party that has not placed his health information at issue, the party seeking access must proceed under subsection (a)(9) [subsection (9) of this section], which permits a patient to raise his privacy interests.

Subsection (a)(4) [subsection (4) of this section] allows for patient records to be used where mental or physical condition is relevant to execution or witnessing of a will. In litigation over testamentary capacity, for example, the best evidence of whether the testator had a "sound mind" may be the testator's medical record at the time of execution of the will. Subsection (b)(4) [evidently a reference to subsection (a)(4) since there never was a subsection (b)(4)] allows compulsory process as to that evidence. See
Mont.Code Ann. § 50-16-314(2)(a) (1980) (adopting the same exception to a general ban on compulsory process or discovery of health-care information) [repealed 1987].

Subsection (a)(6) [subsection (6) of this section] allows disclosure of relevant health-care information in civil or criminal commitment proceedings. The purpose of such a proceeding is for the court to assess a patient's health to determine whether that patient is in need of treatment. Without access to the patient's health-care record, a commitment proceeding would be meaningless. See R.I.Gen.Laws § 5.37.3-62(B) (1980).

Subsection (a)(7) [subsection (7) of this section] recognizes that patient records are often the only evidence available to investigate and prosecute health-care providers or researchers who may have violated the law. A privacy statute intended to protect patients must not shield illegal behavior by providers. Therefore, this subsection permits the use of compulsory process or discovery to obtain information as part of an investigation or proceeding in which a health-care provider is suspected of a violation of law, is a defendant, or is otherwise a party. However, no information obtained under this section can be used in an investigation of, or action against, a patient, unless the action or investigation directly relates to payment by third-party payors for a patient's health care. However, this section does not prohibit use of information obtained by law enforcement personnel that, coincidentally, was also obtained independently under this subsection.

Subsection (a)(9) [subsection (9) of this section] permits the use of compulsory process or discovery to obtain health-care information where the party seeking access establishes, in an individual case, that its interests outweigh the privacy interests of the patient involved. This section, with its balancing test, should be used wherever patient health-care information is sought to challenge the competency or credibility of a witness, or a party who has not placed his health-care information at issue.

This test is also applicable to a case where the subject of information receives notice that his or her records are being sought and has the opportunity to contest access. For example, if the court is convinced that society's interests are greater than the patient's privacy interest, government officials would be permitted to use process to force production of records where there has been a felony committed, but the victim is reluctant or afraid to testify, for example in rape or child abuse cases.

This subsection will also permit the use of ex parte or in camera proceedings to obtain a patient's health-care information. Such proceedings should be rarely used, but might be necessary, for example, where a prosecutor is seeking a search warrant and does not want the patient to know.

Compiler's Comments

2003 Amendments -- Composite Section: Chapter 396 in (1)(a) near beginning after "patient has" substituted "authorized" for "consented"; in (1)(k) at end after "46-4-301" inserted "or a similar federal law"; and made minor changes in style. Amendment effective April 18, 2003.

Chapter 504 inserted (1)(i) concerning proceeding under Title 41, chapter 3; and made minor changes in style. Amendment effective October 1, 2003.

1989 Amendment: Inserted (1)(j) regarding information requested pursuant to subpoena; inserted (2) regarding disclosure prohibited by law; corrected internal reference; and made minor changes in phraseology and form.

Source: This section is derived from subsection (a) of section 2-105 of the Uniform Health-Care Information Act as adopted by the National Conference of Commissioners on Uniform State Laws.

Cross-References

Government health care information -- legal proceedings, 50-16-605.

Case Notes

DECISIONS UNDER CURRENT LAW

Confidentiality of Patients' Health Care Information -- Costs of Producing Copies of Nonconfidential Information to Be Borne by Health Care Providers: In a class action suit seeking monetary damages for excessive fees allegedly charged for copies of patient medical records, the District Court concluded that patient names were not confidential and ordered that the health care providers produce the names and bear the cost of producing the information as to requests for copies. The Supreme Court held that names of medical
patients are protected under constitutional and statutory law and vacated the portion of the order requiring the production of patients' names, noting that patient notification would have to be accomplished through other means, such as an opt-in notification. The order was affirmed to the extent that names of nonpatient requesters, such as attorneys and insurance companies whose privacy was not at issue, be provided. Further, because 50-16-525 requires health care providers to maintain patient records for 3 years, the District Court did not abuse its discretion in ordering the providers to bear the cost of producing the information. St. James Community Hosp., Inc. v. District Court, 2003 MT 261, 317 M 419, 77 P3d 534 (2003).

Investigative Subpoena for Medical Records Not Issued for Overly Broad Time Period: The District Court issued an investigative subpoena related to an accident on January 3, 2000, to compel production of Bilant's medical records back to 1996. The affidavit for subpoena was issued May 10, 2000. The health care provider supplied records back to 1991. Bilant moved to suppress the information on grounds that the subpoena was overly broad in supplying any information after the date of the accident and prior to the date specified in the subpoena. The Supreme Court affirmed the validity of the investigative subpoena. The inclusion of time between January 3 and May 10 did not render the subpoena defective because there was a legitimate nexus between prescriptions issued before January 3 and prescription refills issued during subsequent months. Further, if a health care provider discloses medical information beyond what is allowed by law, the remedy lies with the health care provider and not with law enforcement through a motion to suppress. The question of the production of medical records beyond those required by the subpoena was a matter beyond the scope of Supreme Court review, and receipt by the state of records that contained information outside the scope and time period requested did not justify suppression of those portions of the records sought by and yielded pursuant to an otherwise legally sufficient investigative subpoena. St. v. Bilant, 2001 MT 249, 307 M 113, 36 P3d 883 (2001).

Revealing Limited Medical Information During Police Interview Not Considered Waiver of Constitutional Right to Confidentiality in Medical Records -- Voluntary Medical Information Outside Scope of Fruit of Poisonous Tree Doctrine -- Adequate Probable Cause for Investigative Subpoena of Medical Records: Bilant was involved in a three-car accident and was subsequently arrested for DUI and a seat belt violation. During an interview following the arrest, Bilant revealed to an officer that he had taken pain medication on the day of the accident. The officer called Bilant's health care provider for confirmation, and the provider confirmed that Bilant had a prescription for a drug similar to the pain medication that he mentioned. The officer then procured an investigative subpoena regarding documentation on all prescriptions issued to Bilant, including any advisory warnings, and the provider sent Bilant's entire medical file. Bilant contended that the state violated both his constitutional right to privacy and the statutory protections of this section. The state maintained that Bilant waived his claim of confidentiality in his medical information when he voluntarily revealed his use of pain medication to the officer. The Supreme Court agreed with Bilant. Medical records are quintessentially private and deserve the utmost constitutional protection. None of the statutory prerequisites for disclosure of the medical records were met. In deciding to reveal limited medical information in a police interview, Bilant did not forfeit his constitutional right to subsequently claim confidentiality in his medical records. The officer conducted an illegal search in seeking the constitutionally protected private medical information without probable cause and the benefit of an investigative subpoena under 46-4-301, and the information gleaned from the telephone call should have been suppressed. Bilant then contended that the use of the illegally obtained information formed an improper basis for the investigative subpoena and that the results of the subpoena should also have been suppressed pursuant to the fruit of the poisonous tree doctrine, which forbids the use of evidence that comes to light as the result of an initially illegal act. However, on this point, the Supreme Court disagreed with Bilant. One exception to the doctrine is that the derivative evidence is admissible if it is obtained from an independent source. Here, Bilant himself provided the source by giving voluntary medical information from other than the illegal telephone inquiry. The Supreme Court recognized that an investigative subpoena seeking constitutionally protected medical information requires greater justification for state access than the administration of justice rationale used to obtain public information under 46-4-301, so in reviewing the probable cause basis for constitutionally protected material, the court excised the illegal evidence from the application and reviewed the remaining information de novo to determine whether probable cause existed for issuing the subpoena. In this case, even when the information subject to suppression was excised, the remaining
Discovery Exception Inapplicable -- Blood Sample Admissible Under Other Law: After Henning's motion in limine for suppression of a voluntarily given blood sample was denied, he entered a plea of DUI upon the condition that the plea could be withdrawn if the District Court ruled his blood sample inadmissible. The District Court found that the state had a compelling state interest that outweighed Henning's privacy interest under 50-16-535. The Supreme Court held that subsection (1)(i) of this section is inapplicable because it applies only to discovery of health care information, and Henning did not contend that his blood test was not subject to discovery. The Supreme Court found the results of the test admissible under 61-8-404(1)(a) and admissible under the rationale of St. v. Kirkaldie, 179 M 283, 587 P2d 1298 (1978). St. v. Henning, 258 M 488, 853 P2d 1223, 50 St. Rep. 626 (1993), distinguished in St. v. Nelson, 283 M 231, 941 P2d 441 (1997).

Attorney General's Opinions

OPINIONS UNDER FORMER LAW

Court Order -- Investigative Subpoena:

A County Attorney may seek an investigative subpoena under the provisions of 46-4-301 through 46-4-306 in order to compel a health care provider to release confidential health care information. 38 A.G. Op. 82 (1980). (Opinion issued under former 50-16-314, which was repealed by sec. 31, Ch. 632, L. 1987.)

Law Review Articles


Collateral References

Hospitals + 5; Physicians and Surgeons + 12, 15(8), (9); Torts + 8.5(1), (2).

41 C.J.S. Hospitals §§ 13, 15; 70 C.J.S. Physicians, Surgeons, and Other Health-Care Providers §§ 58 through 61; 77 C.J.S. Right of Privacy and Publicity § 1, et seq.

Physician-patient privilege as extending to patient's medical or hospital records. 10 ALR 4th 552.

Patient's right to disclosure of his or her own medical records under state freedom of information act. 26 ALR 4th 701.

MCA 50-16-535, MT ST 50-16-535

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 16. HEALTH CARE INFORMATION
PART 7. REPORT OF EXPOSURE TO INFECTIOUS DISEASE
50-16-701, Definitions

As used in this part, the following definitions apply:

(1) "Airborne infectious disease" means an infectious disease transmitted from person to person by an aerosol, including but not limited to infectious tuberculosis.

(2) "Department" means the department of public health and human services provided for in 2-15-2201.

(3) "Designated officer" means the emergency services organization's representative and the alternate whose names are on record with the department as the persons responsible for notifying an emergency services provider of exposure.

(4) "Emergency services organization" means a public or private organization that provides emergency services to the public.

(5) "Emergency services provider" means a person employed by or acting as a volunteer with an emergency services organization, including but not limited to a law enforcement officer, firefighter, emergency medical technician, paramedic, corrections officer, or ambulance service attendant.

(6) "Exposure" means the subjecting of a person to a risk of transmission of an infectious disease through the commingling of the blood or bodily fluids of the person and a patient or in another manner as defined by department rule.

(7) "Health care facility" has the meaning provided in 50-5-101 and includes a public health center as defined in 7-34-2102.

(8) "Infectious disease" means human immunodeficiency virus infection, hepatitis B, hepatitis C, hepatitis D, communicable pulmonary tuberculosis, meningococcal meningitis, and any other disease capable of being transmitted through an exposure that has been designated by department rule.

(9) "Infectious disease control officer" means the person designated by the health care facility as the person who is responsible for notifying the emergency services provider's designated officer and the department of an infectious disease as provided for in this part and by rule.

(10) "Patient" means an individual who is sick, injured, wounded, or otherwise incapacitated or helpless.

History: En. Sec. 1, Ch. 390, L. 1989; amd. Sec. 1, Ch. 476, L. 1993; amd. Sec. 110, Ch. 418, L. 1995; amd. Sec. 287, Ch. 546, L. 1995; amd. Sec. 13, Ch. 93, L. 1997; amd. Sec. 1, Ch. 146, L. 1999.
Chapter 546 in definition of Department substituted "department of public health and human services provided for in 2-15-2201" for "department of health and environmental sciences provided for in 2-15-2101". Amendment effective July 1, 1995.

Transition: Section 499, Ch. 418, L. 1995, provided: "The provisions of 2-15-131 through 2-15-137 apply to [this act]."

Saving Clause: Section 503, Ch. 418, L. 1995, was a saving clause.

Saving Clause: Section 571, Ch. 546, L. 1995, was a saving clause.

1993 Amendment: Chapter 476 inserted definitions of airborne infectious disease, designated officer, emergency services provider, exposure, and infectious disease control officer; in definition of infectious disease, after "communicable disease", deleted "designated by department rule as", before "exposure" deleted "unprotected", and after "exposure" inserted the remainder of the definition specifying certain diseases; and deleted definition of unprotected exposure that read: ""Unprotected exposure" means exposure of a person to an infectious disease in a manner defined by department rule as likely to allow transmission of the disease, including but not limited to mouth-to-mouth resuscitation and commingling of the blood or body fluids of the person and a patient."

MCA 50-16-701, MT ST 50-16-701

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MCA 50-16-702, MT ST 50-16-702

West's Montana Code Annotated
Title 50. Health and Safety
Chapter 16. Health Care Information
Part 7. Report of Exposure to Infectious Disease

50-16-702. Notification of exposure to infectious disease--report of exposure to disease

(1)(a) If an emergency services provider acting in an official capacity attends a patient prior to or during transport or assists in transporting a patient to a health care facility and the emergency services provider has had an exposure, the emergency services provider may request the designated officer to submit the form required by department rule to the health care facility on the emergency services provider's behalf. The form must be provided for in rules adopted by the department and must include the emergency services provider's name and other information required by the department, including a description of the exposure. The designated officer shall submit the completed form to the health care facility receiving the patient as soon as possible after the request for submission by the emergency services provider. Submission of the form to the health care facility is an indication that the emergency services provider was exposed and a verification that the designated officer and the emergency services provider believe that the emergency services provider was exposed.

(b) If the exposure described on the form occurred in a manner that may allow infection by HIV, as defined in 50-16-1003, by a mode of transmission recognized by the U.S. department of health and human services, centers for disease control and prevention, then submission of the form to the health care facility constitutes a request to the patient's physician to perform an HIV diagnostic test pursuant to 50-16-1014.

(c) Upon receipt of the report of exposure from a designated officer, the health care facility shall notify the designated officer in writing whether or not a determination has been made that the patient has or does not have an infectious disease. If a determination has been made and the patient has been found:

(i) to have an infectious disease, the information required by 50-16-703 must be provided by the health care facility;

(ii) to not have an infectious disease, the date on which the patient was transported to the health care facility must be provided by the health care facility.

(2) If a health care facility receiving a patient determines that the patient has an airborne infectious disease, the health care facility shall, within 48 hours after the determination was made, notify the designated officer and the department of that fact. The notice to the department must include the name of the emergency services organization that transported the patient to the health care facility. The department shall, within 24 hours after receiving the notice, notify the designated officer of the emergency services provider who transported the patient.

(3) A designated officer who receives the notification from a health care facility required by 50-16-703(2) or by subsection (1)(c) of this section shall immediately provide the information contained in the notification to the emergency services provider for whom the report of exposure was filed or who was exposed to a patient with an airborne infectious disease.


ADMINISTRATIVE CODE REFERENCES

Exposure form, see MT ADC 37.104.805.

Transmittable infectious diseases, see MT ADC 37.104.801.
MCA 50-16-702, MT ST 50-16-702

LIBRARY REFERENCES

Health 399.
Westlaw Key Number Search: 198Hk399.

MCA 50-16-702, MT ST 50-16-702

Current through all 2009 legislation

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MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 16. HEALTH CARE INFORMATION
PART 7. REPORT OF EXPOSURE TO INFECTIOUS DISEASE

50-16-703. Notification of precautions after exposure to infectious disease

(1) After a patient is transported to a health care facility and if a physician determines that the transported patient has an infectious disease, the physician shall inform the infectious disease control officer of the health care facility of the determination within 24 hours after the determination is made.

(2) If it is determined that the infectious disease is airborne or a report of exposure was filed concerning the patient under 50-16-702, the health care facility shall provide the notification required by subsection (3) orally within 48 hours after the time of diagnosis and in writing within 72 hours after diagnosis to the designated officer of each emergency services organization known to the health care facility to have provided emergency services to the patient prior to or during transportation to the health care facility.

(3) The notification must state the disease to which the emergency services provider was exposed, the appropriate medical precautions and treatment that the exposed person needs to take, the date on which the patient was transported to the health care facility, and the time that the patient arrived at the facility.

History: En. Sec. 3, Ch. 390, L. 1989; amd. Sec. 3, Ch. 476, L. 1993; amd. Sec. 3, Ch. 146, L. 1999.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

1999 Amendment: Chapter 146 in (1) near beginning after "facility" deleted "a physician shall inform the health care facility within 24 hours" and at end after "disease" inserted "the physician shall inform the infectious disease control officer of the health care facility of the determination within 24 hours after the determination is made"; at beginning of (2) inserted "If it is determined that the infectious disease is airborne or a report of exposure was filed concerning the patient under 50-16-702", after "facility shall" substituted "provide the notification required by subsection (3) orally" for "orally notify", and after "emergency services" substituted "organization known to the health care facility to have provided emergency services to the patient prior to or during transportation to the health care facility" for "provider who attended the patient prior to or during transport or who transported the patient with the infectious disease"; at end of (3) inserted "the date on which the patient was transported to the health care facility, and the time that the patient arrived at the facility"; and made minor changes in style. Amendment effective October 1, 1999.

1993 Amendment: Chapter 476 in (1), after "facility", inserted "within 24 hours"; deleted (1)(b) and (1)(c) that read: "(b) a report of unprotected exposure to that patient has been filed; and" (c) the physician believes the unprotected exposure is capable of transmitting the infectious disease"; in (2) inserted "the designated officer of the emergency services provider who attended the patient prior to or during transport or who transported the patient with the infectious disease" and deleted "the person who filed the report in 50-16-702 of"; and at beginning of (3) inserted "The notification must state" and substituted "the emergency services provider was" for "he may have been".

Attorney General's Opinions

Required Report of Transportation of Patient With Transmittable Infectious Disease Not in Conflict With Uniform Health Care Information Act:

Section 50-16-525 contains a statutory exception for disclosure of health care information as otherwise specifically provided by law. Therefore, the disclosure required under 50-16-702 and this section when a patient transported to a health care facility is diagnosed with a transmittable infectious disease is not in conflict with the general provision of the Uniform Health Care Information Act that health care information may not be disclosed without the patient's written authorization. 45 A.G. Op. 31 (1994).

Transportation of Patient With Transmittable
Infectious Disease -- Report Required:

When a patient transported to a health care facility is diagnosed with one of the transmittable infectious diseases designated in ARM 16.30.801 (renumbered 37.104.801), the health care facility is required to report that fact to the designated officer of the emergency medical services provider who assisted the patient, even if no report of exposure was filed with the facility concerning the transported patient and there is no evidence that an actual exposure occurred. 45 A.G. Op. 31 (1994).

MCA 50-16-703, MT ST 50-16-703

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 16. HEALTH CARE INFORMATION
PART 7. REPORT OF EXPOSURE TO
INFECTIOUS DISEASE

50-16-704. Confidentiality -- penalty for violation -- immunity from liability

(1) The name of the person diagnosed as having an infectious disease may not be released to anyone, including the emergency services provider who was exposed, nor may the name of the emergency services provider who was exposed be released to anyone other than the emergency services provider, except as required by this part, by department rule concerning reporting of communicable disease, or as allowed by Title 50, chapter 16, part 5.

(2) A person who violates the provisions of this section is guilty of a misdemeanor and upon conviction shall be fined not less than $500 or more than $10,000, be imprisoned in the county jail not less than 3 months or more than 1 year, or both.

(3) A health care facility, a representative of a health care facility, a physician, or the designated officer of an emergency services provider's organization may not be held jointly or severally liable for providing the notification required by 50-16-703 when the notification is made in good faith or for failing to provide the notification if good faith attempts to contact an exposed person of exposure are unsuccessful.

History: En. Sec. 5, Ch. 390, L. 1989; amd. Sec. 4, Ch. 476, L. 1993; amd. Sec. 4, Ch. 146, L. 1999.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

1993 Amendment: Chapter 476 in (1), after "suffered the", deleted "unprotected" and after "anyone" inserted "including the emergency services provider who was exposed"; in (3), after "physician", inserted "or the designated officer of an emergency services provider's organization" and near end substituted "an exposed person of exposure" for "a person filing a report of unprotected exposure"; and made minor changes in style.

Cross-References

Physician's immunity from liability, 37-2-312.

MCA 50-16-704, MT ST 50-16-704

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 16. HEALTH CARE INFORMATION
PART 7. REPORT OF EXPOSURE TO INFECTIOUS DISEASE
50-16-705. Rulemaking authority

The department shall adopt rules to:

(1) define what constitutes an exposure to an infectious disease;

(2) specify the infectious diseases subject to this part;

(3) specify the information about an exposure that must be included in a report of exposure;

(4) specify recommended medical precautions and treatment for each infectious disease subject to this part; and

(5) specify recordkeeping and reporting requirements necessary to ensure compliance with the notification requirements of this part.

History: En. Sec. 4, Ch. 390, L. 1989; amd. Sec. 5, Ch. 476, L. 1993; amd. Sec. 5, Ch. 146, L. 1999.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

1999 Amendment: Chapter 146 inserted (5) concerning recordkeeping and reporting rules; and made minor changes in style. Amendment effective March 23, 1999.

1993 Amendment: Chapter 476 in three places, before "exposure", deleted "unprotected".

Effective Date: Section 7, Ch. 390, L. 1989, provided: "[Section 4] [codified as 50-16-705] and [this section] are effective on passage and approval." Approved March 30, 1989.

Cross-References

MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 16. HEALTH CARE INFORMATION
PART 7. REPORT OF EXPOSURE TO
INFECTIOUS DISEASE

50-16-706 through 50-16-710 reserved.

<General Materials (GM) - References, Annotations,
or Tables>

MCA 50-16-706 through 50-16-710, MT ST 50-16-
706 through 50-16-710

Current through the 2005 Regular Session of the 59th
Legislature

END OF DOCUMENT
(1) The health care facility and the emergency services organization shall develop internal procedures for implementing the provisions of this part and department rules.

(2) The health care facility must have available at all times a person to receive the form provided for in 50-16-702 containing a report of exposure to infectious disease.

(3) The health care facility shall designate an infectious disease control officer and an alternate who will be responsible for maintaining the required records and notifying designated officers in accordance with the provisions of this part and the rules promulgated under this part and shall provide the names of the designated officer and the alternate to the department.

(4) The emergency services organization shall name a designated officer and an alternate and shall provide their names to the department.

History: En. Sec. 7, Ch. 476, L. 1993; amd. Sec. 6, Ch. 146, L. 1999.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

1999 Amendment: Chapter 146 in (1) substituted "this part" for "this chapter"; at end of (3) substituted "this part and the rules promulgated under this part and shall provide the names of the designated officer and the alternate to the department" for "this chapter and the rules promulgated under this chapter"; in (4) at end inserted "and shall provide their names to the department"; and made minor changes in style. Amendment effective October 1, 1999.

MCA 50-16-711, MT ST 50-16-711

A personal representative of a deceased patient's estate may exercise all of the deceased patient's rights under this part. If there is no personal representative or upon discharge of the personal representative, a deceased patient's rights under this part may be exercised by the surviving spouse, a parent, an adult child, an adult sibling, or any other person who is authorized by law to act for the deceased person.

History: En. Sec. 18, Ch. 396, L. 2003.
50-16-805. Disclosure of information for workers' compensation and occupational disease claims and law enforcement purposes

(1) To the extent provided in 39-71-604 and 50-16-527, a signed claim for workers' compensation or occupational disease benefits authorizes disclosure to the workers' compensation insurer, as defined in 39-71-116, by the health care provider.

(2) A health care provider may disclose health care information about an individual for law enforcement purposes if the disclosure is to:

(a) federal, state, or local law enforcement authorities to the extent required by law; or

(b) a law enforcement officer about the general physical condition of a patient being treated in a health care facility if the patient was injured by the possible criminal act of another.

History: En. Sec. 19, Ch. 396, L. 2003.
When health care information available by compulsory process

(1) Health care information may not be disclosed by a health care provider pursuant to compulsory legal process or discovery in any judicial, legislative, or administrative proceeding unless:

(a) the patient has authorized in writing the release of the health care information in response to compulsory process or a discovery request;

(b) the patient has waived the right to claim confidentiality for the health care information sought;

(c) the patient is a party to the proceeding and has placed the patient's physical or mental condition in issue;

(d) the patient's physical or mental condition is relevant to the execution or witnessing of a will or other document;

(e) the physical or mental condition of a deceased patient is placed in issue by any person claiming or defending through or as a beneficiary of the patient;

(f) a patient's health care information is to be used in the patient's commitment proceeding;

(g) the health care information is for use in any law enforcement proceeding or investigation in which a health care provider is the subject or a party, except that health care information so obtained may not be used in any proceeding against the patient unless the matter relates to payment for the patient's health care or unless authorized under subsection (1)(i);

(h) a court has determined that particular health care information is subject to compulsory legal process or discovery because the party seeking the information has demonstrated that there is a compelling state interest that outweighs the patient's privacy interest; or

(i) the health care information is requested pursuant to an investigative subpoena issued under 46-4-301 or similar federal law.

(2) This part does not authorize the disclosure of health care information by compulsory legal process or discovery in any judicial, legislative, or administrative proceeding where disclosure is otherwise prohibited by law.


LIBRARY REFERENCES

Mental Health § 41.
Privileged Communications and Confidentiality § 263.
Westlaw Key Number Searches: 257Ak41; 311Hk263.
C.J.S. Mental Health §§ 61 to 63, 70 to 77, 79 to 82.
MCA 50-16-812, MT ST 50-16-812

MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 16. HEALTH CARE INFORMATION
PART 8. HEALTH CARE INFORMATION PRIVACY REQUIREMENTS FOR PROVIDERS SUBJECT TO HIPAA

50-16-812. Method of compulsory process

(1) Unless the court for good cause shown determines that the notification should be waived or modified, if health care information is sought under 50-16-811(1)(b), (1)(d), or (1)(e) or in a civil proceeding or investigation under 50-16-811(1)(h), the person seeking compulsory process or discovery shall mail a notice by first-class mail to the patient or the patient's attorney of record of the compulsory process or discovery request at least 10 days before presenting the certificate required under subsection (2) of this section to the health care provider.

(2) Service of compulsory process or discovery requests upon a health care provider must be accompanied by a written certification, signed by the person seeking to obtain health care information or by the person's authorized representative, identifying at least one subsection of 50-16-811 under which compulsory process or discovery is being sought. The certification must also state, in the case of information sought under 50-16-811(1)(b), (1)(d), or (1)(e) or in a civil proceeding under 50-16-811(1)(h), that the requirements of subsection (1) of this section for notice have been met. A person may sign the certification only if the person reasonably believes that the subsection of 50-16-811 identified in the certification provides an appropriate basis for the use of compulsory process or discovery. Unless otherwise ordered by the court, the health care provider shall maintain a copy of the process and the written certification as a permanent part of the patient's health care information.

(3) In response to service of compulsory process or discovery requests, when authorized by law, a health care provider may deny access to the requested health care information. If access to requested health care information is denied by the health care provider, the health care provider shall submit to the court by affidavit or other reasonable means an explanation of why the health care provider believes that the information should be protected from disclosure.

(4) When access to health care information is denied, the court may order disclosure of health care information, with or without restrictions as to its use, as the court considers necessary. In deciding whether to order disclosure, the court shall consider the explanation submitted by the health care provider and any arguments presented by interested parties.

(5) A health care provider required to disclose health care information pursuant to compulsory process may charge a reasonable fee, not to exceed the fee provided for in 50-16-816, and may deny examination or copying of the information until the fee is paid.

(6) Production of health care information under 50-16-811 and this section does not in itself constitute a waiver of any privilege, objection, or defense existing under other law or rule of evidence or procedure.

History: En. Sec. 21, Ch. 396, L. 2003.

50-16-816. Reasonable fees

Unless prohibited by federal law, a reasonable fee for providing copies of health care information may not exceed 50 cents for each page for a paper copy or photocopy. A reasonable fee may include an administrative fee that may not exceed $15 for searching and handling recorded health care information.

History: En. Sec. 22, Ch. 396, L. 2003.
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 16. HEALTH CARE INFORMATION
PART 10. AIDS EDUCATION AND
PREVENTION

50-16-1003. Definitions

As used in this part, the following definitions apply:

(1) "AIDS" means acquired immune deficiency syndrome as further defined by the department in accordance with standards promulgated by the centers for disease control of the United States public health service.

(2) "Contact" means a person who has been exposed to the test subject in a manner, voluntary or involuntary, that may allow HIV transmission in accordance with modes of transmission recognized by the centers for disease control of the United States public health service.

(3) "Department" means the department of public health and human services provided for in 2-15-2201.

(4) "Health care facility" means a health care institution, private or public, including but not limited to a hospital, nursing home, clinic, blood bank, blood center, sperm bank, or laboratory.

(5) "Health care provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state or who is licensed, certified, or otherwise authorized by the laws of another state to provide health care in the ordinary course of business or practice of a profession. The term does not include a person who provides health care solely through the sale or dispensing of drugs or medical devices.

(6) "HIV" means the human immunodeficiency virus, identified as the causative agent of AIDS, and all HIV and HIV-related viruses that damage the cellular branch of the human immune or neurological systems and leave the infected person immunodeficient or neurologically impaired.

(7) "HIV-related condition" means a chronic disease resulting from infection with HIV, including but not limited to AIDS and asymptomatic seropositivity for HIV.

(8) "HIV-related test" means a test approved by the federal food and drug administration, including but not limited to an enzyme immunoassay and a western blot, that is designed to detect the presence of HIV or antibodies to HIV.

(9) "Informed consent" means a freely executed oral or written grant of permission by the subject of an HIV-related test, by the subject's legal guardian, or, if there is no legal guardian and the subject of the test is unconscious or otherwise mentally incapacitated, by the subject's next of kin or significant other or a person designated by the subject in hospital records to act on the person's behalf to perform an HIV-related test after the receipt of pretest counseling.

(10) "Legal guardian" means a person appointed by a court to assume legal authority for another who has been found incapacitated or, in the case of a minor, a person who has legal custody of the minor.

(11) "Local board" means a county, city, city-county, or district board of health.

(12) "Local health officer" means a county, city, city-county, or district health officer appointed by the local board.

(13) "Next of kin" means an individual who is a parent, adult child, grandparent, adult sibling, or legal spouse of a person.

(14) "Person" means an individual, corporation, organization, or other legal entity.

(15) "Posttest counseling" means counseling, conducted at the time that the HIV-related test results are given, and includes, at a minimum, written materials provided by the department.

(16) "Pretest counseling" means the provision of counseling to the subject prior to conduct of an HIV-related test, including, at a minimum, written materials developed and provided by the department.

(17) "Release of test results" means a written authorization for disclosure of HIV-related test results that:

(a) is signed and dated by the person tested or the person authorized to act for the person tested; and

(b) specifies the nature of the information to be
disclosed and to whom disclosure is authorized.

(18) "Significant other" means an individual living in a current spousal relationship with another individual but who is not legally a spouse of that individual.


Compiler's Comments

1997 Amendments: Chapter 197 in definition of health care provider, near middle of first sentence after "laws of this state", inserted "or who is licensed, certified, or otherwise authorized by the laws of another state"; in definition of written informed consent, in (a)(ii) after "confidentiality", substituted "specimen collection" for "blood drawing" and near end substituted "specimen" for "blood sample" (voided by Ch. 524); and made minor changes in style. Amendment effective April 3, 1997.

Chapter 524 in definition of contact deleted (a) that read: "(a) an individual identified by the subject of an HIV-related test as a past or present sexual partner or as a person with whom the subject has shared hypodermic needles or syringes"; inserted definition of written informed consent; deleted definition of written informed consent that read: ""Written informed consent" means an agreement in writing that is freely executed by the subject of an HIV-related test, by the subject's legal guardian, or, if there is no legal guardian and the subject is unconscious or otherwise mentally incapacitated, by the subject's next of kin or significant other or a person designated by the subject in hospital records to act on the subject's behalf. The written informed consent must include at least the following:

(i) an explanation of the test, including its purpose, potential uses, limitations, and the meaning of its results;

(ii) an explanation of the procedures to be followed for confidentiality, blood drawing, and counseling, including notification that the test is voluntary and that consent may be withdrawn at any time until the blood sample is taken;

(iii) an explanation of whether and to whom the subject's name and test results may be disclosed;

(iv) a statement that the test may be obtained anonymously if the subject wishes;

(v) the name and address of a health care provider whom the subject approves to receive the subject's test results and to provide the subject with posttest counseling; and

(vi) if the consent is for a test being performed as part of an application for insurance, a statement that only a positive test result will be reported to the designated health care provider and that negative test results may be obtained by the subject from the insurance company.

(b) The department shall develop an agreement form that may be used for purposes of this subsection"; and made minor changes in style.

1995 Amendments: Chapter 418 in definition of Department substituted "department of public health" for "department of health and environmental sciences"; and made minor changes in style. Amendment effective July 1, 1995.

Chapter 546 in definition of Department substituted "department of public health and human services provided for in 2-15-2201" for "department of health and environmental sciences provided for in 2-15-2101". Amendment effective July 1, 1995.

Transition: Section 499, Ch. 418, L. 1995, provided: "The provisions of 2-15-131 through 2-15-137 apply to [this act]."

Saving Clause: Section 503, Ch. 418, L. 1995, was a saving clause.

Saving Clause: Section 571, Ch. 546, L. 1995, was a saving clause.

1991 Amendment: In definition of contact inserted (b) concerning a person exposed to the test subject in a manner allowing HIV transmission; in definition of HIV-related test substituted "test approved by the federal food and drug administration" for "laboratory test"; in definition of health care provider substituted present text concerning person authorized to provide health care for "physician, nurse, paramedic, psychologist, dentist, public health department agent, or other
person providing medical, nursing, psychological, or other health care services of any kind"; inserted definitions of local board, local health officer, and next of kin; in definition of pretest counseling, after "provision of", substituted "counseling" for "written materials" and after "test" inserted "including, at a minimum"; in definition of release of test results, in (a) after "dated", inserted "by the person tested or the person authorized to act for the person tested"; inserted definition of significant other; in definition of written informed consent, in (a) after "guardian", inserted "or, if there is no legal guardian and the subject is unconscious or otherwise mentally incapacitated, by the subject's next of kin, significant other, or a person designated by the subject in hospital records to act on the subject's behalf, and", at end of (a)(ii) inserted "until the blood sample is taken", at beginning of (a)(iii) substituted "an explanation" for "a discussion", and inserted (a)(v) concerning name and address of health care provider and (a)(vi) concerning test performed as part of insurance application; and made minor changes in style. Amendment effective July 1, 1991.

**Severability:** Section 8, Ch. 544, L. 1991, was a severability clause.

**Attorney General's Opinions**

*Conditions for Release of Information About HIV Test Subject -- Imminent Danger to Health or Safety:*

In reconciling the apparent conflict in the provision of medical information as contained in the Uniform Health Care Information Act and the AIDS Prevention Act, the Attorney General determined that a health care provider may release health care information about the subject of an HIV-related test, including the identity of the subject, to a contact, as defined in this section, without the subject's authorization, only when the health care provider reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of the contact or other individual. 44 A.G. Op. 37 (1992).
It is the intent of the legislature to treat AIDS, HIV-related conditions, and HIV infection in the same manner as other communicable diseases, including sexually transmitted diseases, by adopting the most currently accepted public health practices with regard to testing, reporting, partner notification, and disease intervention. Nothing in this section is intended to prohibit the department from allowing testing for HIV infection to be performed and reported without identification of the subject of the test. The department shall adopt rules, as provided in 50-1-202, to reflect this policy.

History: En. Sec. 1, Ch. 524, L. 1997.

NOTES, REFERENCES, AND ANNOTATIONS

Cross-References

Disclosure of communicable diseases, 50-16-603.

Sexually transmitted diseases, Title 50, ch. 18.
(1) An HIV-related test may be ordered only by a health care provider and only after receiving the informed consent of:

(a) the subject of the test;
(b) the subject's legal guardian;
(c) the subject's next of kin or significant other if:
   (i) the subject is unconscious or otherwise mentally incapacitated;
   (ii) there is no legal guardian;
   (iii) there are medical indications of an HIV-related condition; and
   (iv) the test is advisable in order to determine the proper course of treatment of the subject; or
(d) the subject's next of kin or significant other or the person, if any, designated by the subject in hospital records to act on the subject's behalf if:
   (i) the subject is in the hospital; and
   (ii) the circumstances in subsections (1)(c)(i) and (1)(c)(ii) exist.

(2) When a health care provider orders an HIV-related test, the provider also certifies that informed consent has been received prior to ordering an HIV-related test.

(3) Before the subject of the test gives informed consent, the health care provider ordering the test or the provider's designee shall give pretest counseling to:

(a) the subject;
(b) the subject's legal guardian;
(c) the subject's next of kin or significant other if:
   (i) the subject is unconscious or otherwise mentally incapacitated; and
   (ii) there is no guardian; or
(d) the subject's next of kin or significant other or the person, if any, designated by the subject in hospital records to act on the subject's behalf if:
   (i) the subject is in the hospital; and
   (ii) the circumstances in subsections (1)(c)(i) and (1)(c)(ii) exist.

(4) A health care provider who does not provide HIV-related tests on an anonymous basis shall inform each person who wishes to be tested that anonymous testing is available at one of the counseling-testing sites established by the department, or elsewhere.

(5) The subject of an HIV-related test or any of the subject's representatives authorized by subsection (1) to act in the subject's stead shall designate, after giving informed consent, a health care provider to receive the results of an HIV-related test. The designated health care provider shall inform the subject or the subject's representative of the results in person.

(6) At the time that the subject of a test or the subject's representative is given the test results, the health care provider or the provider's designee shall give the subject or the subject's representative posttest counseling.

(7) If a test is performed as part of an application for insurance, the insurance company shall obtain the informed consent in writing and ensure that:

(a) negative results can be obtained by the subject or the subject's representative upon request; and
(b) positive results are returned to the health care provider designated by the subject or the subject's representative.

(8) A minor may consent or refuse to consent to be the subject of an HIV-related test, pursuant to 41-1-402.

(9) Subsections (1) through (6) do not apply to:
(a) the performance of an HIV-related test by a health care provider or health care facility that procures, processes, distributes, or uses a human body part donated for a purpose specified under Title 72, chapter 17, if the test is necessary to assure medical acceptability of the gift for the purposes intended;

(b) the performance of an HIV-related test for the purpose of research if the testing is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher;

(c) the performance of an HIV-related test when:

(i) the subject of the test is unconscious or otherwise mentally incapacitated;

(ii) there are medical indications of an HIV-related condition;

(iii) the test is advisable in order to determine the proper course of treatment of the subject; and

(iv) none of the individuals listed in subsection (1)(b), (1)(c), or (1)(d) exists or is available within a reasonable time after the test is determined to be advisable; or

(d) the performance of an HIV-related test conducted pursuant to 50-18-107 or 50-18-108, with the exception that the pretest and posttest counseling must still be given.

(10) (a) If an agent or employee of a health care facility, a health care provider with privileges at the health care facility, or a person providing emergency services who is described in 50-16-702 has been voluntarily or involuntarily exposed to a patient in a manner that may allow infection by HIV by a mode of transmission recognized by the centers for disease control of the United States public health service, the physician of the patient shall, upon request of the exposed person, notify the patient of the exposure and seek informed consent in accordance with guidelines of the centers for disease control for an HIV-related test of the patient. If informed consent cannot be obtained, the health care facility, in accordance with the infectious disease exposure guidelines of the health care facility, may, without the consent of the patient, conduct the test on previously drawn blood or previously collected bodily fluids to determine if the patient is in fact infected. A health care facility is not required to perform a test authorized in this subsection. If a test is conducted pursuant to this subsection, the health care facility shall inform the patient of the results and provide the patient with posttest counseling. The patient may not be charged for a test performed pursuant to this subsection. The results of a test performed pursuant to this subsection may not be made part of the patient's record and are subject to 50-16-1009(1).

(b) For the purposes of this subsection (10), "informed consent" means an agreement that is freely executed, either orally or in writing, by the subject of an HIV-related test, by the subject's legal guardian, or, if there is no legal guardian and the subject is incapacitated, by the subject's next of kin, significant other, or a person designated by the subject in hospital records to act on the subject's behalf.

(11) A knowing or purposeful violation of this section is a misdemeanor punishable by a fine of $1,000 or imprisonment for up to 6 months, or both.

History: En. Sec. 4, Ch. 614, L. 1989; amd. Sec. 2, Ch. 544, L. 1991; amd. Sec. 6, Ch. 476, L. 1993; amd. Sec. 3, Ch. 524, L. 1997.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

1997 Amendment: Chapter 524 in (1), in introductory clause after "receiving the", deleted "written"; in (3), in introductory clause after "test", substituted "gives informed consent" for "executes an informed consent agreement"; in (5), near middle after "designate", substituted "after giving" for "as part of a written"; in (7), in introductory clause after "company", substituted "shall obtain the informed consent in writing and" for "must"; in (10)(a), near end of first sentence and at beginning of second sentence before "informed", deleted "written"; in (10)(b), near beginning before "informed", deleted "written", after "agreement" deleted "in writing", and after "executed" inserted "either orally or in writing"; and made minor changes in style.

1993 Amendment: Chapter 476 in (10)(a) deleted reference to subsection (1) of 50-16-702; and made minor changes in style.
1991 Amendment: At beginning of (1) substituted "An HIV-related test may be ordered only by a health care provider and only after" for "A person may not request an HIV-related test without first"; inserted (1)(c) concerning consent of next of kin or significant other; inserted (1)(d) concerning consent of next of kin, significant other, or the designated person; in (2) substituted present text concerning certifying informed consent for "A health care provider shall certify in writing that informed consent has been received prior to requesting testing. Testing may only be requested by a health care provider"; in (3), at end, inserted "the health care provider ordering the test or his designee must give pretest counseling to"; inserted (3)(a) requiring counseling for the subject of the test; inserted (3)(c) requiring counseling for the subject's next of kin or significant other; inserted (3)(d) requiring counseling for the subject's next of kin, significant other, or the designated person; in (4), at end, inserted "or elsewhere"; in (5), at beginning, substituted "The subject of an HIV-related test or any of the subject's representatives authorized by subsection (1) to act in the subject's stead shall designate, as part of his written informed consent, a health care provider to receive the results of an HIV-related test. The designated health care provider" for "The results of an HIV-related test must be given to the health care provider designated by the subject, who" and in second sentence, after "subject", inserted "or the subject's representative"; in (6), in two places, inserted "or the subject's representative" and after "test results" inserted "the health care provider or the provider's designee"; inserted (7) concerning a test performed as part of an insurance application; in (9) changed subsection reference; inserted (9)(c) concerning performance of test under certain conditions; inserted (10)(a) concerning exposure of certain persons to potential HIV infection; inserted (10)(b) defining informed written consent; and made minor changes in style. Amendment effective July 1, 1991.

Severability: Section 8, Ch. 544, L. 1991, was a severability clause.

Law Review Articles


MCA 50-16-1007, MT ST 50-16-1007

Current through the 2005 Regular Session of the 59th
50-16-1014. Screening and pretest information

(1) Screening for HIV-related conditions must be considered routine and must be incorporated into the patient's general informed consent for medical care on the same basis as other screening and diagnostic tests.

(2) Screening for HIV-related conditions must be voluntary and undertaken with the patient's knowledge and understanding that HIV diagnostic testing is planned.

(3) Patients must be informed orally or in writing that HIV diagnostic testing will be performed.

(4) If a patient declines an HIV diagnostic test, this decision must be documented in the patient's medical record.

(1) Screening for HIV-related conditions must be considered routine and must be incorporated into the pregnant patient's general informed consent for medical care on the same basis as other routine prenatal screening and diagnostic tests.

(2) Screening for HIV-related conditions in pregnant patients must be voluntary and undertaken with the patient's knowledge and understanding that HIV diagnostic testing is planned.

(3) Pregnant patients must be informed orally or in writing that HIV diagnostic testing will be performed.

(4) If a pregnant patient declines an HIV diagnostic test, this decision must be documented in the patient's medical record.

(5) Physicians and other health care providers licensed to provide prenatal care to pregnant women may:

   (a) offer an HIV diagnostic test in the third trimester to pregnant women who were not tested earlier in the pregnancy; and

   (b) offer a repeat HIV diagnostic test in the third trimester of pregnancy, preferably before 36 weeks of gestation, to each of their pregnant patients at high risk for acquiring HIV-related conditions.


MCA 50-16-1015, MT ST 50-16-1015

Current through all 2009
Physicians and other health care providers licensed to provide prenatal care to pregnant women shall, if medically indicated:

(1) offer a rapid HIV diagnostic test to pregnant women in labor with unknown or undocumented HIV status;

(2) offer antiretroviral prophylaxis without waiting for the results of the confirmatory test if a rapid HIV diagnostic test or a standard HIV diagnostic test is positive.

MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 18. SEXUALLY TRANSMITTED DISEASES
PART 1. GENERAL PROVISIONS

50-18-101. Sexually transmitted diseases defined

Human immunodeficiency virus (HIV), syphilis, gonorrhea, chancroid, chlamydia genital infections, lymphogranuloma venereum, and granuloma inguinale are sexually transmitted diseases. Sexually transmitted diseases are contagious, infectious, communicable, and dangerous to public health.

History: En. Sec. 97, Ch. 197, L. 1967; R.C.M. 1947, 69-4601(part); amd. Sec. 1, Ch. 440, L. 1989; amd. Sec. 2, Ch. 71, L. 1993.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments


1993 Statement of Intent: The statement of intent attached to Ch. 71, L. 1993, provided: "It is the intent of the legislature to amend 46-18-256 and 50-18-101 in order to comply with federal requirements of the Crime Control Act of 1990 that requires states to enact laws related to human immunodeficiency virus (HIV) testing of certain convicted offenders or be subject to reduced federal funding.

Upon the request of the victim or the victim's representatives, testing and the test results must be made available for the victim's information. Testing information may or may not reveal exposure to the HIV virus. If exposed, the victim can seek medical treatment and take steps to protect others from the further spread of the epidemic.

This bill is intended to be a benefit to public

50-18-108. Examination and treatment of prisoners

Any person confined or imprisoned in any state, county, or municipal prison within the state may be examined for a sexually transmitted disease. If infected, the person must be treated by health authorities.


ADMINISTRATIVE CODE REFERENCES

Investigation of a case, see MT ADC 37.114.314.

LIBRARY REFERENCES

Health 387, 388.
Prisons 192, 197.
Westlaw Key Number Searches: 198Hk387; 198Hk388; 310k192; 310k197.
As used in this part, the following definitions apply:

(1) "Department" means the department of public health and human services provided for in 2-15-2201.

(2) "Health care provider" means a licensed physician, a physician assistant, a registered nurse, an advanced practice registered nurse, a naturopathic physician, or a direct-entry midwife practicing within the scope of the provider's professional license.

(3) "Standard serological test" means a test for syphilis, rubella immunity, and blood group, including ABO (Landsteiner blood type designation--O, A, B, AB) and RH (Dd) type, and a screening for hepatitis B surface antigen, approved by the department.


ADMINISTRATIVE CODE REFERENCES

Approved tests, see MT ADC 37.12.801.

Hepatitis Type B (acute or chronic), see MT ADC 37.114.540.
(1) Every female, regardless of age or marital status, seeking prenatal care from a health care provider is required to submit a blood specimen for the purpose of a standard serological test. In submitting the specimen to the laboratory, the health care provider shall designate it as a prenatal test.

(2) A health care provider who attends a pregnant woman shall at the first professional visit take the blood sample and submit it to a laboratory.

(3) A person permitted to attend a pregnant woman, but not permitted to take blood samples, must have the sample taken by a person permitted to take blood samples and submit it to a laboratory.

(4) A health care provider who violates this part is guilty of a misdemeanor. However, a health care provider who requests a sample of blood in accordance with this provision and whose request is refused is not guilty of a violation of this section.


<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

2001 Amendment: Chapter 351 in (1) in two places substituted "health care provider" for "physician"; in (2) at beginning substituted "health care provider" for "physician or other person authorized by law to practice obstetrics"; in (4) at beginning of first sentence substituted "health care provider" for "physician or other person required to take the blood sample" and near beginning of second sentence substituted "health care provider" for "person"; and made minor changes in style. Amendment effective October 1, 2001.

Cross-References

Misdemeanor penalty when none specified, 46-18-212.

Newborn hearing screening, Title 53, ch. 19, part 4.

MCA 50-19-103, MT ST 50-19-103

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 19. PREGNANT WOMEN AND
NEWBORN INFANTS
PART 1. SEROLOGICAL TEST FOR WOMEN
SEEKING PRENATAL CARE

50-19-105. Report of positive test results

All positive laboratory tests for any sexually transmitted diseases or hepatitis B surface antigen must be reported to the department by the laboratory preparing the test. The department shall prescribe the form and way of reporting.

History: En. Sec. 3, Ch. 228, L. 1973; R.C.M. 1947, 69-6703(2); amd. Sec. 13, Ch. 440, L. 1989; amd. Sec. 6, Ch. 351, L. 2001.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

2001 Amendment: Chapter 351 near middle inserted "or hepatitis B surface antigen". Amendment effective October 1, 2001.

1989 Amendment: Substituted "sexually transmitted" for "venereal"; and made minor change in phraseology.

Saving Clause: Section 21, Ch. 440, L. 1989, was a saving clause.

Severability: Section 22, Ch. 440, L. 1989, was a severability clause.

Cross-References

Sexually transmitted diseases, Title 50, ch. 18.

MCA 50-19-105, MT ST 50-19-105

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 19. PREGNANT WOMEN AND NEWBORN INFANTS
PART 1. SEROLOGICAL TEST FOR WOMEN SEEKING PREGNATAL CARE

50-19-109. Waiver of test by court when contrary to patient's religious creed

The district court within the county wherein any person affected by this part resides may waive the requirements of this part as to the person if the judge is satisfied, by affidavit or other proof, that the tests required by the part are contrary to the tenets or practices of the religious creed of which the applicant is an adherent and that the public health and welfare will not be injuriously affected thereby.

History: En. Sec. 8, Ch. 228, L. 1973; R.C.M. 1947, 69-6708.

NOTES, REFERENCES, AND ANNOTATIONS

Cross-References


MCA 50-19-109, MT ST 50-19-109

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
Newborn screening and followup for metabolic and genetic disorders

(1) A person in charge of a facility in which a child is born or a facility in which a newborn is provided care or a person responsible for the registration of the birth of a newborn shall ensure that each newborn is administered tests designed to detect inborn metabolic and genetic disorders as required under rules adopted by the department.

(2) The tests must be done by an approved laboratory. An approved laboratory must be the laboratory of the department or a laboratory approved by the department.

(3) The department shall contract with one or more providers qualified to provide followup services, including counseling and education, for children and parents of children identified with metabolic or genetic disorders to ensure the availability of followup services.


ADMINISTRATIVE CODE REFERENCES

Abnormal test result, see MT ADC 37.57.316.
Definitions, see MT ADC 37.57.301.
Infant born outside health care facility, see MT ADC 37.57.307.

Newborns other than those with very low birth weight, see MT ADC 37.57.305.

Responsibilities of registrar of birth: administrator of health care facility, see MT ADC 37.57.320.

State laboratory: responsibility for tests, see MT ADC 37.57.321.

Transfer of newborn infant, see MT ADC 37.57.306.

Transfusion: when blood specimen taken, see MT ADC 37.57.315.

Very low birth weight (under 1,500 grams) newborns, see MT ADC 37.57.304.

LIBRARY REFERENCES

Health 19192, 256, 278.
Westlaw Key Number Searches: 198Hk192; 198Hk256; 198Hk278.
C.J.S. Hospitals § 18.
C.J.S. Physicians, Surgeons, and Other Health Care Providers §§ 71 to 73.

NOTES OF DECISIONS

Malpractice claims against foreign service providers 1

1. Malpractice claims against foreign service providers

Proper respect for mutual interests of interstate access to medical services and quality rendering of those same services required that malpractice claim arising from alleged negligence of the Health Division of the Oregon Department of Human Resources in performing a test designed to detect an inborn metabolic disorder in a child born in Montana be pursued by the guardian ad litem in the Oregon courts.

Even if nature of Oregon's contacts with Montana in respect to performance by the Health Division of the Oregon Department of Human Resources of a test designed to detect inborn metabolic disorders in all children born in Montana was such that assertion of in personam jurisdiction in guardian ad litem's medical malpractice action would not offend due process, where Oregon was not engaging in activities within Montana, but was performing a regional medical service within its own boundaries, and assertion of jurisdiction would impinge unnecessarily upon harmonious interstate relations which were part and parcel of spirit of cooperative federalism, considerations of comity warranted dismissal of action to preclude subjecting Oregon to possibility of lawsuits in every state served by its medical testing facilities. Rules Civ. Proc., Rule 4B(1), (1)(b, e); MCA 50-19-203. Simmons v. State, 1983, 206 Mont. 264, 670 P.2d 1372. Courts 12(2.25)

Contract which the state of Oregon negotiated with the Montana Department of Health and Environmental Sciences and which called for the Health Division of the Oregon Department of Human Resources to perform a test designed to detect inborn metabolic disorders on all children born in Montana did not amount to such substantial or continuous and systematic activity in Montana as to justify assertion of long-arm jurisdiction by a Montana court over Oregon in action wherein it was sued by guardian ad litem for alleged negligent activity in Oregon in incorrectly analyzing results of test performed on child born with a metabolic defect. Rules Civ. Proc., Rule 4B(1), (1)(b, e); MCA 50-19-203. Simmons v. State, 1983, 206 Mont. 264, 670 P.2d 1372. Courts 12(2.10)

Nonresident defendants can usually foresee that their conduct or actions may ultimately have an impact in another state, but crucial factor with respect to due process analysis in connection with assertion of long-arm jurisdiction is whether their conduct or actions are such that they should have reasonably anticipated being haled into court there. Rules Civ. Proc., Rule 4B(1), (1)(b, e); MCA 50-19-203; U.S.C.A. Const. Amend. 14, Simmons v. State, 1983, 206 Mont. 264, 670 P.2d 1372. Courts 12(2.10)

Telephone and mail communication to the Montana Department of Health and Environmental Sciences of the results of metabolic disorder tests performed pursuant to contract by the Health Division of the Oregon Department of Human Resources for children born in Montana did not transform nature of the contact between the states into a purposeful injection into Montana so as to subject Oregon to in personam jurisdiction of Montana court in negligence action brought by guardian ad litem of child born with a metabolic disorder. Rules Civ. Proc., Rule 4B(1), (1)(b, e); MCA 50-19-203. Simmons v. State, 1983, 206 Mont. 264, 670 P.2d 1372. Courts 12(2.25)

The state of Oregon, in its role as a regional provider of lab testing for metabolic disorders in newborn infants, could not be said to have purposefully availed itself of the benefits and protections of the Montana forum so as to be subjected to "in personam jurisdiction" in negligence action by guardian ad litem for infant since the blood sample traveled to Oregon for tests conducted, the results were then returned to Montana for the ultimate benefit of the child, and Oregon was compensated only for its marginal costs of operation. Rules Civ. Proc., Rule 4B(1), (1)(b, e); MCA 50-19-203. Simmons v. State, 1983, 206 Mont. 264, 670 P.2d 1372. Courts 12(2.25)

Acquiring in personam jurisdiction over Oregon in suit wherein guardian ad litem for minor child born with a metabolic disorder alleged negligence on part of the Health Division of the Oregon Department of Health Resources in performing test designed to detect disorder in child would be unreasonable, notwithstanding that guardian could receive up to $300,000 under Montana's tort claims law as opposed to $100,000 under Oregon's tort liability statute, where citizens of Montana, due to state's low birthrate and apparently high start-up costs of developing lab facilities and procedures, would not otherwise have the benefit of suitable testing procedures without access to the program in Oregon. ORS 30.270; Rules Civ. Proc., Rule 4B(1), (1)(b, e); MCA 50-19-203. Simmons v. State, 1983, 206 Mont. 264, 670 P.2d 1372. Courts 12(2.25)

MCA 50-19-203, MT ST 50-19-203

Current through all 2009 legislation
This part may be cited as the "Montana Abortion Control Act".

History: En. 94-5-613 by Sec. 1, Ch. 284, L. 1974; R.C.M. 1947, 94-5-613; amd. Sec. 61, Ch. 130, L. 2005.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

2005 Amendment: Chapter 130 at beginning after "This" substituted "part" for "chapter shall be known and". Amendment effective October 1, 2005.

MCA 50-20-101, MT ST 50-20-101

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 20. ABORTION
PART 1. MONTANA ABORTION CONTROL ACT
50-20-102. Statement of purpose -- findings

(1) The legislature reaffirms the tradition of the state of Montana to protect every human life, whether unborn or aged, healthy or sick. In keeping with this tradition and in the spirit of our constitution, we reaffirm the intent to extend the protection of the laws of Montana in favor of all human life. It is the policy of the state to preserve and protect the lives of all human beings and to provide protection for the viable human life. The protection afforded to a person by Montana's constitutional right of privacy is not absolute, but may be infringed upon by a compelling state interest. The legislature finds that a compelling state interest exists in the protection of viable life.

(2) The legislature finds, with respect to 50-20-401, that:

(a) the United States supreme court has determined that states have a legitimate interest in protecting both a woman's health and the potentiality of human life and that each interest grows and reaches a compelling point at various stages of a woman's approach to the full term of a pregnancy;

(b) the court has also determined that subsequent to viability, the state in promoting its interest in the potentiality of human life may, if it chooses, regulate and even proscribe abortion except when necessary, in appropriate medical judgment, for the preservation of the life or health of the woman;

(c) the holdings referred to in subsections (2)(a) and (2)(b) apply to unborn persons in order to extend to unborn persons the inalienable right to defend their lives and liberties;

(d) absent clear proof that an abortion is necessary to save the life of the woman, the abortion of a viable person is an infringement of that person's rights; and

(e) the state has a duty to protect innocent life and that duty has grown to a compelling point with respect to partial-birth abortion.
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 20. ABORTION
PART 1. MONTANA ABORTION CONTROL ACT
50-20-103. Legislative intent

It is the intent of the legislature to restrict abortion to the extent permissible under decisions of appropriate courts or paramount legislation.

History: En. 94-5-623 by Sec. 11, Ch. 284, L. 1974; R.C.M. 1947, 94-5-623.

<General Materials (GM) - References, Annotations, or Tables>

MCA 50-20-103, MT ST 50-20-103

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 20. ABORTION
PART I. MONTANA ABORTION CONTROL ACT
50-20-104, Definitions

As used in this chapter, the following definitions apply:

(1) "Abortion" means the use or prescription of any instrument, medicine, drug, or other substance or device to intentionally terminate the pregnancy of a woman known to be pregnant, with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus.

(2) "Attempted abortion" or "attempted" means an act or an omission of a statutorily required act that, under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance of an abortion in violation of this chapter.

(3) "Department" means the department of public health and human services provided for in 2-15-2201.

(4) "Facility" means a hospital, health care facility, physician's office, or other place in which an abortion is performed.

(5) "Informed consent" means voluntary consent to an abortion by the woman upon whom the abortion is to be performed only after full disclosure to the woman by:

(a) the physician who is to perform the abortion of the following information:

(i) the particular medical risks associated with the particular abortion procedure to be employed, including, when medically accurate, the risks of infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility;

(ii) the probable gestational age of the unborn child at the time the abortion is to be performed; and

(iii) the medical risks of carrying the child to term;

(b) the physician or an agent of the physician:

(i) that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;

(ii) that the father is liable to assist in the support of the child, even in instances in which the father has offered to pay for the abortion; and

(iii) that the woman has the right to review the printed materials described in 50-20-304; and

(c) the physician or the agent that the printed materials described in 50-20-304 have been provided by the department and that the materials describe the unborn child and list agencies that offer alternatives to abortion.

(6) "Viability" means the ability of a fetus to live outside the mother's womb, albeit with artificial aid.

History: En. 94-5-615 by Sec. 3, Ch. 284, L. 1974; amd. Sec. 38, Ch. 187, L. 1977; R.C.M. 1947, 94-5-615(part); amd. Sec. 122, Ch. 418, L. 1995; amd. Sec. 299, Ch. 546, L. 1995; amd. Sec. 9, Ch. 566, L. 1995.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

1995 Amendments: Chapter 418 in definition of Department substituted "department of public health" for "department of health and environmental sciences"; and made minor changes in style. Amendment effective July 1, 1995.

Chapter 546 in definition of Department substituted "department of public health and human services provided for in 2-15-2201" for "department of health and environmental sciences provided for in Title 2, chapter 15, part 21"; and made minor changes in style. Amendment effective July 1, 1995.

Chapter 566 in (1) substituted current definition of abortion for former language that read: ""Abortion" means the performance of, assistance or participation in the performance of, or submission to an act or operation intended to terminate a pregnancy without live birth"; inserted definition of attempted abortion or attempted; in definition of informed
MCA 50-20-104, **MT ST 50-20-104**

consent, in (a) after "information", deleted "as is reasonably chargeable to the knowledge of the physician in his professional capacity", substituted (a)(i) through (a)(iii) (see 1995 Session Law for text) for former language in (a) through (c) that read: "(a) the stage of development of the fetus, the method of abortion to be utilized, and the effects of such abortion method upon the fetus;

(b) the physical and psychological effects of abortion; and

(c) available alternatives to abortion, including childbirth and adoption", inserted (b) requiring full disclosure by physician or agent of medical assistance benefits, child support liability, and woman's right to review printed material, and inserted (c) requiring full disclosure by physician or agent that printed materials have been provided by Department and describe unborn child and list agencies offering alternatives to abortion; and made minor changes in style. Amendment effective July 1, 1995.

*Transition:* Section 499, Ch. 418, L. 1995, provided: "The provisions of 2-15-131 through 2-15-137 apply to [this act]."

*Saving Clause:* Section 503, Ch. 418, L. 1995, was a saving clause.

*Saving Clause:* Section 571, Ch. 546, L. 1995, was a saving clause.

*Construction:* Section 12, Ch. 566, L. 1995, provided: "[Sections 1 through 10] [Title 50, ch. 20, part 3, 50-20-104, and 50-20-106] may not be construed as creating or recognizing a right to abortion. [Sections 1 through 10] [Title 50, ch. 20, part 3, 50-20-104, and 50-20-106] do not make lawful any abortion that is currently unlawful."

*Severability:* Section 13, Ch. 566, L. 1995, was a severability clause.

MCA 50-20-104, **MT ST 50-20-104**

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
(1) The department shall make regulations to provide for the humane disposition of dead infants or fetuses.

(2) The department shall make regulations for a comprehensive system of reporting of maternal deaths and complications within the state resulting directly or indirectly from abortion, subject to the provisions of 50-20-110(5).

(3) The department shall report to the attorney general any apparent violation of this chapter.

History: (1)En. 94-5-617 by Sec. 5, Ch. 284, L. 1974; amd. Sec. 13, Ch. 338, L. 1977; Sec. 94-5-617, R.C.M. 1947; (2)En. 94-5-621 by Sec. 9, Ch. 284, L. 1974; Sec. 94-5-621, R.C.M. 1947; (3)En. 94-5-619 by Sec. 7, Ch. 284, L. 1974; Sec. 94-5-619, R.C.M. 1947; R.C.M. 1947, 94-5-617(4), 94-5-619(6), 94-5-621.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.


Administrative Rules

Title 37, chapter 21, subchapter 1, ARM Documentations and studies of abortions.

Case Notes

Recordkeeping and Reporting Requirements: Requiring and regulating recordkeeping and reporting by physicians and agencies performing abortions are constitutionally permissible so long as not administered in an unduly burdensome manner. Doe v. Deschamps, 461 F. Supp. 682 (D.C. Mont. 1976).
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 20. ABORTION
PART 1. MONTANA ABORTION CONTROL ACT

50-20-106, Informed consent

(1) An abortion may not be performed without the informed consent of the woman upon whom the abortion is to be performed. The informed consent must be received at least 24 hours prior to the abortion and certified prior to or at the time of the abortion.

(2) Informed consent must be certified by a written statement in a form prescribed by the department and signed by the physician and the woman upon whom the abortion is to be performed in which the physician certifies that the physician has made the full disclosure provided in 50-20-104(5) and in which the woman upon whom the abortion is to be performed acknowledges that the disclosures have been made to the woman and that the woman voluntarily consents to the abortion.

(3) If a woman chooses to review the written materials described in 50-20-304, the materials must be provided to her at least 24 hours before the abortion or be mailed to the woman by certified mail, with delivery restricted to the addressee, at least 72 hours before the abortion.

(4) The information required in 50-20-104(5)(a) may be provided by telephone without conducting a physical examination or tests of the patient. The information may be based on facts supplied to the physician by the woman and other relevant information that is reasonably available to the physician. The information may not be provided by a tape recording but must be provided during a consultation in which the physician is able to ask questions of the woman and the woman is able to ask questions of the physician. If a physical examination, tests, or the availability of other information subsequently indicates, in the medical judgment of the physician, a revision of information previously provided to the patient, the revised information may be communicated to the patient at any time prior to the performance of the abortion.

(5) The information required in 50-20-104(5)(b) may be provided by a tape recording if provision is made to record or otherwise register specifically whether the woman does or does not choose to review the printed materials.

(6) The informed consent or consent provided for in this section is not required if a licensed physician certifies that the abortion is necessary because of a medical emergency as defined in 50-20-303.

(7) An executive officer, administrative agency, or public employee of the state or of any local governmental body may not issue any order requiring an abortion or coerce any woman to have an abortion. A person may not coerce any woman to have an abortion.

(8) Violation of subsections (1) through (7) is a misdemeanor.

History: (1), (3) thru (5)En. 94-5-616 by Sec. 4, Ch. 284, L. 1974; Sec. 94-5-616, R.C.M. 1947; (2)En. 94-5-615 by Sec. 3, Ch. 284, L. 1974; amd. Sec. 38, Ch. 187, L. 1977; Sec. 94-5-615, R.C.M. 1947; R.C.M. 1947, 94-5-615(part), 94-5-616(part); amd. Sec. 10, Ch. 566, L. 1995.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

1995 Amendment: Chapter 566 in first sentence in (1), after "consent", inserted "of the woman upon whom the abortion is to be performed" and inserted second sentence requiring receipt of informed consent 24 hours prior to abortion and certification of consent prior to abortion; in (2) substituted "50-20-104(5)" for "50-20-104(4)"; inserted (3) requiring that materials be provided, if requested for review, at least 24 hours before abortion or delivered by mail at least 72 hours before abortion; inserted (4) authorizing required information to be provided by telephone without conducting patient examination or tests; inserted (5) authorizing tape recording providing information if woman's choice to review material is specifically registered; in (6), after "or consent", inserted "provided for in this section" and after "necessary" substituted "because of a medical emergency as defined in 50-20-303" for "to preserve the life of the mother"; in (8) substituted "subsections (1) through (7)" for "subsections (1) and (4)"; and made minor changes in style. Amendment effective July 1, 1995.

MCA 50-20-106, MT ST 50-20-106

Construction: Section 12, Ch. 566, L. 1995, provided: "[Sections 1 through 10] [Title 50, ch. 20, part 3, 50-20-104, and 50-20-106] may not be construed as creating or recognizing a right to abortion. [Sections 1 through 10] [Title 50, ch. 20, part 3, 50-20-104, and 50-20-106] do not make lawful any abortion that is currently unlawful."

Severability: Section 13, Ch. 566, L. 1995, was a severability clause.

Cross-References

Penalty for misdemeanor, 50-20-112.

Administrative Rules

ARM 37.21.104 Certificate of informed consent.

Case Notes

Informed Consent Requirement: In accordance with the U.S. Supreme Court decision in Planned Parenthood of Central Missouri v. Danforth, 428 US 52 (1976), Montana's statute requiring informed consent prior to an abortion is constitutional as the decision to abort is important and a woman's full knowledge and awareness of the decision may be assured constitutionally by the state to the extent of requiring her prior written consent. (See 1995 amendment.) Doe v. Deschamps, 461 F. Supp. 682 (D.C. Mont. 1976).

Spousal Notice Requirement -- Unconstitutional as Written: Because Montana's statute requiring notice by a woman to her husband prior to an abortion does not prescribe the method of giving notice, it is unduly restrictive and does not afford adequate protection for either the physician or the pregnant woman and is therefore unconstitutional as written. (See 1995 amendment.) Doe v. Deschamps, 461 F. Supp. 682 (D.C. Mont. 1976).

Law Review Articles


Who Decides? The Next Abortion Issue: A Discussion of Fathers' Rights, 91 W. Va. L. Rev. 165

MONTANA CODE ANNOTATED
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History: En. 94-5-616 by Sec. 4, Ch. 284, L. 1974;
R.C.M. 1947, 94-5-616(part).

<General Materials (GM) - References, Annotations,
or Tables>

MCA 50-20-107, MT ST 50-20-107

Current through the 2005 Regular Session of the 59th
Legislature

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 20. ABORTION
PART 1. MONTANA ABORTION CONTROL ACT
50-20-108. Protection of premature infants born alive

(1) A person commits an offense, as defined in 45-5-102 through 45-5-104, if he purposely, knowingly, or negligently causes the death of a premature infant born alive, if such infant is viable.

(2) Whenever a premature infant which is the subject of abortion is born alive and is viable, it becomes a dependent and neglected child subject to the provisions of state law, unless:

(a) the termination of the pregnancy is necessary to preserve the life of the mother; or

(b) the mother and her spouse or either of them have agreed in writing in advance of the abortion or within 72 hours thereafter to accept the parental rights and responsibilities of the premature infant if it survives the abortion procedure.

(3) No person may use any premature infant born alive for any type of scientific research or other kind of experimentation except as necessary to protect or preserve the life and health of such premature infant born alive.

(4) Violation of subsection (3) of this section is a felony.

History: En. 94-5-617 by Sec. 5, Ch. 284, L. 1974; amd. Sec. 13, Ch. 338, L. 1977; R.C.M. 1947, 94-5-617(1) thru (3), (5); amd. Sec. 9, Ch. 610, L. 1987.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Cross-References

Child abuse, neglect, and dependency, Title 41, ch. 3.

Penalty for felony, 50-20-112.

Case Notes

Criminal Liability Provision -- Constitutionality:

MCA 50-20-108, MT ST 50-20-108

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
(1) Except as provided in 50-20-401, an abortion may not be performed within the state of Montana:

(a) except by a licensed physician or physician assistant;

(b) after viability of the fetus, except as provided in subsection (2).

(2) An abortion under subsection (1)(b) may be performed only to preserve the life or health of the mother and only if:

(a) the judgment of the physician who is to perform the abortion is first certified in writing by the physician, setting forth in detail the facts relied upon in making the judgment; and

(b) two other licensed physicians have first examined the patient and concurred in writing with the judgment. The certification and concurrence in this subsection (2)(b) are not required if a licensed physician certifies that the abortion is necessary to preserve the life of the mother.

(3) The timing and procedure used in performing an abortion under subsection (1)(b) must be such that the viability of the fetus is not intentionally or negligently endangered, as the term "negligently" is defined in 45-2-101. The fetus may be intentionally endangered or destroyed only if necessary to preserve the life or health of the mother.

(4) For purposes of this section, "health" means the prevention of a risk of substantial and irreversible impairment of a major bodily function.

(5) The supervision agreement of a physician assistant may provide for performing abortions.

(6) Violation of subsections (1) through (3) is a felony.

History: En. 94-5-618 by Sec. 6, Ch. 284, L. 1974; amd. Sec. 20, Ch. 359, L. 1977; R.C.M. 1947, 45-2-101; amd. Sec. 7, Ch. 485, L. 1981; amd. Sec. 2, Ch. 321, L. 1995; amd. Sec. 11, Ch. 354, L. 1995; amd. Sec. 2, Ch. 314, L. 1997; amd. Sec. 2, Ch. 479, L. 1999; amd. Sec. 27, Ch. 519, L. 2005.
Chapter 321 inserted (5) excluding performance of abortions from the utilization plan of a physician assistant-certified; in (6) inserted reference to subsection (5); and made minor changes in style.

Chapter 354 in (3), at end after "45-2-101", deleted "(37)"; and made minor changes in style. Amendment effective April 11, 1995.

Style changes in the chapters were slightly different. In each case, the codifier chose the most appropriate.

Severability: Section 18, Ch. 354, L. 1995, was a severability clause.

1981 Amendment: Changed internal references to section 45-2-101 in subsection (3) to reflect amendment of that section.

Cross-References


Licensing of physicians, Title 37, ch. 3, part 3.

Penalty for felony and for misdemeanor, 50-20-112.

Case Notes

Prohibition Against Abortion by Physician Assistant-Certified Unconstitutional Violation of Right of Privacy: After the decision in Mazurek v. Armstrong, 520 US 968, 138 L Ed 2d 162, 117 S Ct 1865 (1997), ibid., Dr. Armstrong and Cahill, a physician assistant-certified, filed this case in state District Court challenging the constitutionality of 37-20-103 and this section, which prohibit a physician assistant-certified from performing abortions. The District Court found that the prohibition affected a woman's right to obtain a legal first trimester abortion and that the state had advanced no compelling interest to justify prohibiting Cahill from performing abortions, as she had for 20 years, and granted plaintiffs' motion for a preliminary injunction. Noting that Montana adheres to one of the most stringent protections of its citizens' right of privacy in the United States, exceeding even the federal constitution, the Supreme Court affirmed, holding that legislation that infringes on the exercise of the right of privacy must be reviewed under a strict scrutiny analysis. Under Art. II, sec. 10, Mont. Const., every individual is guaranteed the right to make medical judgments affecting that person's bodily integrity and health, in partnership with a chosen health care provider and free from government interference, except in very limited circumstances not at issue here. The court agreed that the statutory restrictions in question impacted a woman's right to procreative autonomy and her right to seek and obtain a specific lawful medical procedure from the health care provider of her choice, in this case a previability abortion from a physician assistant-certified, and were thus an unconstitutional violation of the right of privacy. Armstrong v. St., 1999 MT 261, 296 M 361, 989 P2d 364, 56 St. Rep. 1045 (1999), following Gryczan v. St., 283 M 433, 942 P2d 112, 54 St. Rep. 699 (1997). See also Intermtln. Planned Parenthood v. St. (Cause No. BDV 97-477) (June 29, 1998) (First Judicial District Court ruling (not appealed to Montana Supreme Court) that the law banning partial-birth abortion procedure infringed on a woman's right to privacy under Art. II, sec. 10, Mont. Const.), and Planned Parenthood of Missoula v. St. (judgment of the First Judicial District, Lewis & Clark County, Dec. 29, 1999, declaring provisions of the Montana Abortion Control Act and the Woman's Right-to-Know Act unconstitutional under Art. II, sec. 10, Mont. Const.).

Standing of Health Care Providers to Litigate Privacy Right of Patient to Obtain Previability Abortion: In a case of first impression, the Supreme Court relied on federal law to decide that the statutes directed at health care providers in 37-20-103 and this section, which prohibit a physician assistant-certified from performing abortions, interfered with the normal functioning of the physician-patient relationship by criminalizing certain procedures. To establish standing to challenge government action: (1) the complaining party must clearly allege past, present, or threatened injury to a property right or civil right; and (2) the alleged injury must be distinguishable from the injury to the public generally but need not be exclusive to the complaining party. In this case, based on the closeness of the physician-patient relationship, the health care providers had standing, on behalf of their women patients, to assert the women's constitutional privacy right under Art. II, sec. 10, Mont. Const., to obtain a previability abortion from the health care provider of their choosing. Armstrong v. St., 1999 MT 261, 296 M 361, 989 P2d 364, 56 St. Rep. 1045 (1999), following Singleton v. Wulff, 428 US 106, 49 L Ed 2d 826, 96 S Ct 2868 (1976). See also Intermtln. Planned...

"Physician Only" Limitation on Performance of Abortions Upheld by U.S. Supreme Court -- No Evidence of "Undue Burden": A group of licensed physicians and one licensed physician assistant-certified practicing in Montana brought an action in the U.S. District Court challenging the constitutionality of this section, claiming that the statute allowing only licensed physicians to conduct abortions imposed an "undue burden" on a woman's right to an abortion within the meaning of Planned Parenthood of SE. Pa. v. Casey, 505 US 833 (1992). The District Court, in Armstrong v. Mazurek, 906 F. Supp. 561 (D.C. Mont. 1995), denied the plaintiffs' motion for a preliminary injunction, finding that the plaintiffs had not established any likelihood of their success on the merits. The Ninth Circuit Court vacated the District Court judgment, holding in Mazurek v. Armstrong, 94 F3d 566 (9th Cir. 1996), that the plaintiffs had shown a "fair chance of success on the merits" of their claim, and remanded the case to the District Court with instructions to reconsider the "balance of hardships" and to determine whether entry of a preliminary injunction was warranted. The District Court entered an injunction pending appeal, and the state was granted certiorari. Noting that the Ninth Circuit Court did not challenge the District Court's conclusion that there was insufficient evidence in the record to show that a statute allowing only physicians to perform abortions in Montana placed an undue burden upon women seeking abortions, the Supreme Court said that the legality of the "physician only" requirement at issue in the present case is controlled by its decision in Casey. In that case, the Supreme Court upheld a "physician only" requirement for the distribution of information to abortion patients when there was insufficient evidence in the record to show that the law was a substantial obstacle to women seeking abortions. The Supreme Court noted that it had already held in Washington v. Davis, 426 US 229 (1976), that courts should not assume an unconstitutional legislative intent even when statutes produce harmful results and that in this case, there was no evidence of an unconstitutional legislative result because there was no evidence of an undue burden. Moreover, the Supreme Court said that the respondent's argument that the Legislature must have had an invalid purpose because all health evidence contradicts the claim that there is any health basis for the statute was foreclosed by its opinion in Casey when it held that states have broad latitude to decide that a particular function must be carried out only by licensed professionals even though objective evidence might suggest that those same tasks could be performed by others. The Supreme Court also noted that it had held in Roe v. Wade, 410 US 113 (1973), and Conn. v. Menillo, 423 US 9 (1975), that a state may limit the performance of abortions to physicians only. For these reasons, the Supreme Court vacated the judgment of the court of appeals and remanded the case to the District Court. Mazurek v. Armstrong, 520 US 968 (1997).

Prohibiting Solicitation and Advertising -- Unconstitutional: This section's prohibition against solicitation for the purpose of attracting a person to come to a doctor or agency to have an abortion is unconstitutional as it infringes upon a person's first amendment rights. (See 1999 amendment.) Doe v. Deschamps, 461 F. Supp. 682 (D.C. Mont. 1976).

Physician Concurrency After Viability -- Constitutionality: The physician concurrence requirement of this section is constitutional because it is limited to the period "after viability of the fetus", when the concern is for the preservation of the "potentiality of life" compatible with the health of the mother. This holding follows the statement in Roe v. Wade, 410 US 113, at 163 (1973), that "State regulation protective of fetal life after viability thus has both logical and biological justifications." At such a point the state may properly require more than the opinion of the woman's attending physician to insure that the potentiality of life is not destroyed. Doe v. Deschamps, 461 F. Supp. 682 (D.C. Mont. 1976).

Law Review Articles

MCA 50-20-109, MT ST 50-20-109
MCA 50-20-109, MT ST 50-20-109

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
(1) Every facility in which an abortion is performed within the state shall keep on file upon a form prescribed by the department a statement dated and certified by the physician who performed the abortion setting forth such information with respect to the abortion as the department by regulation shall require, including but not limited to information on prior pregnancies, the medical procedure employed to administer the abortion, the gestational age of the fetus, the vital signs of the fetus after abortion, if any, and if after viability, the medical procedures employed to protect and preserve the life and health of the fetus.

(2) The physician performing an abortion shall cause such pathology studies to be made in connection therewith as the department shall require by regulation, and the facility shall keep the reports thereof on file.

(3) In connection with an abortion, the facility shall keep on file the original of each of the documents required by this chapter relating to informed consent, consent to abortion, certification of necessity of abortion to preserve the life or health of the mother, and certification of necessity of abortion to preserve the life of the mother.

(4) Such facility shall, within 30 days after the abortion, file with the department a report upon a form prescribed by the department and certified by the custodian of the records or physician in charge of such facility setting forth all of the information required in subsections (1), (2), and (3) of this section, except such information as would identify any individual involved with the abortion. The report shall exclude copies of any documents required to be filed by subsection (3) of this section, but shall certify that such documents were duly executed and are on file.

(5) All reports and documents required by this chapter shall be treated with the confidentiality afforded to medical records, subject to such disclosure as is permitted by law. Statistical data not identifying any individual involved in an abortion shall be made public by the department annually, and the report required by subsection (4) of this section to be filed with the department shall be available for public inspection except insofar as it identifies any individual involved in an abortion. Names and identities of persons submitting to abortion shall remain confidential among medical and medical support personnel directly involved in the abortion and among persons working in the facility where the abortion was performed whose duties include billing the patient or submitting claims to an insurance company, keeping facility records, or processing abortion data required by state law.

(6) Violation of this section is a misdemeanor and is punishable as provided in 46-18-212.

History: En. 94-5-619 by Sec. 7, Ch. 284, L. 1974; R.C.M. 1947, 94-5-619(1) thru (5); amd. Sec. 10, Ch. 228, L. 1981.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

1981 Amendment: Added (6) providing a penalty.

Saving Clause: Section 11, Ch. 228, L. 1981, was a saving section.

Severability: Section 12, Ch. 228, L. 1981, was a severability section.

Cross-References


Adoption and publication of rules, Title 2, ch. 4, part 3.

Confidentiality of health care information, Title 50, ch. 16, part 5.

Administrative Rules

ARM 37.21.105 Confidentiality.

ARM 37.21.110 Report by facility performing abortions.

ARM 37.21.111 Pathology studies.
Case Notes

Recordkeeping and Reporting Requirements: Requiring and regulating recordkeeping and reporting by physicians and agencies performing abortions are constitutionally permissible so long as not administered in an unduly burdensome manner. Doe v. Deschamps, 461 F. Supp. 682 (D.C. Mont. 1976).

MCA 50-20-110, MT ST 50-20-110

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MCA 50-20-111, MT ST 50-20-111

MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 20. ABORTION
PART 1. MONTANA ABORTION CONTROL ACT
50-20-111. Right to refuse participation in abortion

(1) No private hospital or health care facility shall be required contrary to the religious or moral tenets or the stated religious beliefs or moral convictions of its staff or governing board to admit any person for the purpose of abortion or to permit the use of its facilities for such purpose. Such refusal shall not give rise to liability of such hospital or health care facility or any personnel or agent or governing board thereof to any person for damages allegedly arising from such refusal or be the basis for any discriminatory, disciplinary, or other recriminatory action against such hospital or health care facility or any personnel, agent, or governing board thereof.

(2) All persons shall have the right to refuse to advise concerning, perform, assist, or participate in abortion because of religious beliefs or moral convictions. If requested by any hospital or health care facility or person desiring an abortion, such refusal shall be in writing signed by the person refusing, but may refer generally to the grounds of "religious beliefs and moral convictions". The refusal of any person to advise concerning, perform, assist, or participate in abortion shall not be a consideration in respect of staff privileges of any hospital or health care facility or a basis for any discriminatory, disciplinary, or other recriminatory action against such person, nor shall such person be liable to any person for damages allegedly arising from refusal.

(3) It shall be unlawful to interfere or attempt to interfere with the right of refusal authorized by this section. The person injured thereby shall be entitled to injunctive relief, when appropriate, and shall further be entitled to monetary damages for injuries suffered.

(4) Such refusal by any hospital or health care facility or person shall not be grounds for loss of any privileges or immunities to which the granting of consent may otherwise be a condition precedent or for the loss of any public benefits.

(5) As used in this section, the term "person" includes one or more individuals, partnerships, associations, and corporations.

History: En. 94-5-620 by Sec. 8, Ch. 284, L. 1974; R.C.M. 1947, 94-5-620.

NOTES, REFERENCES, AND ANNOTATIONS

Cross-References


Right to refuse participation in sterilization, Title 50, ch. 5, part 5.

MCA 50-20-111, MT ST 50-20-111

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 20. ABORTION
PART 1. MONTANA ABORTION CONTROL ACT
50-20-112. Penalties

(1) A person convicted of deliberate, mitigated, or negligent homicide under this chapter is subject to the penalties prescribed by 45-5-102 through 45-5-104.

(2) A person convicted of a felony other than deliberate, mitigated, or negligent homicide under this chapter is subject to a fine not to exceed $1,000, imprisonment in the state prison for a term not to exceed 5 years, or both.

(3) A person convicted of a misdemeanor under this chapter is subject to a fine not to exceed $500, imprisonment in the county jail for a term not to exceed 6 months, or both.

(4) (a) A penalty may not be imposed against the woman upon whom the abortion is performed or attempted to be performed.

(b) A penalty may not be imposed for failure to comply with the provision of 50-20-106 that requires a written certification that the woman has been informed of the opportunity to review the information referred to in 50-20-304 if the department has not made the written materials available at the time that the physician or the physician's agent is required to inform the woman of the right to review the materials.

History: En. 94-5-622 by Sec. 10, Ch. 284, L. 1974; amd. Sec. 14, Ch. 338, L. 1977; R.C.M. 1947, 94-5-622; amd. Sec. 10, Ch. 610, L. 1987; amd. Sec. 11, Ch. 566, L. 1995.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

1995 Amendment: Chapter 566 inserted (4)(a) prohibiting penalty against woman upon whom abortion is performed or attempted; and inserted (4)(b) prohibiting penalty for failure to comply with requirements to provide written materials if Department has not provided materials to physician or agent. Amendment effective July 1, 1995.

Construction: Section 12, Ch. 566, L. 1995, provided: "[Sections 1 through 10] [Title 50, ch. 20, part 3, 50-20-104, and 50-20-106] may not be construed as creating or recognizing a right to abortion. [Sections 1 through 10] [Title 50, ch. 20, part 3, 50-20-104, and 50-20-106] do not make lawful any abortion that is currently unlawful."

Severability: Section 13, Ch. 566, L. 1995, was a severability clause.

1987 Amendment: In (1) and (2) substituted "deliberate, mitigated, or negligent homicide" for "criminal homicide"; and near end of (1) substituted "45-5-102" for "45-5-101".

MCA 50-20-112, MT ST 50-20-112

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
ACT 50-20-201. Short title

This part may be cited as the "Parental Notice of Abortion Act".

History: En. Sec. 1, Ch. 469, L. 1995.

<General Materials (GM) - References, Annotations, or Tables>

MCA 50-20-201, MT ST 50-20-201

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 20. ABORTION
PART 2. PARENTAL NOTICE OF ABORTION ACT

50-20-202. Legislative purpose and findings

(1) The legislature finds that:

(a) immature minors often lack the ability to make fully informed choices that take into account both immediate and long-range consequences;

(b) the medical, emotional, and psychological consequences of abortion are sometimes serious and can be lasting, particularly when the patient is immature;

(c) the capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion are not necessarily related;

(d) parents ordinarily possess information essential to a physician in the exercise of the physician's best medical judgment concerning the minor;

(e) parents who are aware that their minor daughter has had an abortion may better ensure that the daughter receives adequate medical care after the abortion; and

(f) parental consultation is usually desirable and in the best interests of the minor.

(2) The purpose of this part is to further the important and compelling state interests of:

(a) protecting minors against their own immaturity;

(b) fostering family unity and preserving the family as a viable social unit;

(c) protecting the constitutional rights of parents to rear children who are members of their household; and

(d) reducing teenage pregnancy and unnecessary abortion.

History: En. Sec. 2, Ch. 469, L. 1995.

<MCA 50-20-202, MT ST 50-20-202 Current through the 2005 Regular Session of the 59th Legislature>

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 20. ABORTION
PART 2. PARENTAL NOTICE OF ABORTION
ACT

50-20-203. Definitions

As used in this part, unless the context requires otherwise, the following definitions apply:

1. "Actual notice" means the giving of notice directly in person or by telephone.

2. "Coercion" means restraining or dominating the choice of a minor female by force, threat of force, or deprivation of food and shelter.

3. "Emancipated minor" means a person under 18 years of age who is or has been married or who has been granted an order of limited emancipation by a court as provided in 41-3-438.

4. "Incompetent person" means a person who is an incapacitated person or a protected person who has had a guardian appointed pursuant to Title 72, chapter 5.

5. "Medical emergency" means a condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of the woman's pregnancy to avert the woman's death or a condition for which a delay in treatment will create serious risk of substantial and irreversible impairment of a major bodily function.

6. "Minor" means a female under 18 years of age who is not an emancipated minor.

7. "Physical abuse" means any physical injury intentionally inflicted by a parent or legal guardian on a child.

8. "Physician" means a person licensed to practice medicine under Title 37, chapter 3.

9. "Sexual abuse" has the meaning given in 41-3-102.

History: En. Sec. 3, Ch. 469, L. 1995.
A physician may not perform an abortion upon a minor or an incompetent person unless the physician has given at least 48 hours' actual notice to one parent or to the legal guardian of the pregnant minor or incompetent person of the physician's intention to perform the abortion. The actual notice may be given by a referring physician. The physician who performs the abortion must receive the written statement of the referring physician certifying that the referring physician has given actual notice. If actual notice is not possible after a reasonable effort, the physician or the physician's agent shall give alternate notice as provided in 50-20-205.

History: En. Sec. 4, Ch. 469, L. 1995.

NOTES, REFERENCES, AND ANNOTATIONS

Case Notes

Constitutionality of Judicial Bypass of Parental Notice Requirement Upheld by U.S. Supreme Court: Physicians and other medical personnel brought a civil action in the U.S. District Court of Montana challenging the "judicial bypass" provision in 50-20-212 by which a court could waive the requirement for parental notification of the minor's intent to seek an abortion. The District Court held the bypass provision unconstitutional because Bellotti v. Baird, 443 US 622 (1979), as interpreted by the District Court, required that judicial bypass mechanisms authorize waiver of notice requirements whenever the abortion would be in the best interests of the minor, not just when notification would not be in the minor's best interests. The Ninth Circuit Court, in Wicklund v. Salvagni, 93 F3d 567 (1996), affirmed, stating that it was bound by its prior decision in Glick v. McKay, 937 F2d 434 (1991), in which it struck down a similar parental notification and judicial bypass statute in Nevada. The U.S. Supreme Court pointed out that in Ohio v. Akron Center for Reproductive Health, 497 US 502 (1990) (Akron II), it had upheld a parental notification statute that was virtually indistinguishable from 50-20-212 and in the Akron II opinion declined to decide whether a parental notification statute must have a "judicial bypass" provision to be constitutional, holding only that the Ohio statute at issue in Akron II satisfied any criteria that might be required for a judicial bypass of a parental consent statute. The Supreme Court pointed out that the Ninth Circuit Court affirmed the District Court decision based only upon its previous decision in Glick, and that decision, the Supreme Court said, simply cannot be squared with its decision in Akron II. Because the statute at issue in Akron II was upheld and because that statute is virtually indistinguishable from 50-20-212, the Supreme Court held that 50-20-212 was also constitutional. The Supreme Court held that the court of appeals should have drawn no conclusions from the fact that the statute at issue in Bellotti allowed a court to bypass the parental consent to an abortion if it found that the abortion was in the best interests of the minor, while the statute at issue in the present case allows bypass of notification if notice is not in the best interests of the minor. Lambert v. Wicklund, 520 US 292 (1997). See also Intermttn. Planned Parenthood v. St. (Cause No. BDV 97-477) (June 29, 1998) (First Judicial District Court ruling (not appealed to Montana Supreme Court) that the law banning partial-birth abortion procedure infringed on a woman's right to privacy under Art. II, sec. 10, Mont. Const.), and Planned Parenthood of Missoula v. St. (judgment of the First Judicial District, Lewis & Clark County, Dec. 29, 1999, declaring provisions of the Montana Abortion Control Act and the Woman's Right-to-Know Act unconstitutional under Art. II, sec. 10, Mont. Const.).

MCA 50-20-204, MT ST 50-20-204

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MCA 50-20-205, **MT ST 50-20-205**

MCA 50-20-205, **MT ST 50-20-205**

**MONTANA CODE ANNOTATED**  
**TITLE 50. HEALTH AND SAFETY**  
**CHAPTER 20. ABORTION**  
**PART 2. PARENTAL NOTICE OF ABORTION**

**ACT**  
**50-20-205. Alternate notification**

In lieu of the actual notice required by 50-20-204, notice may be made by certified mail addressed to the parent at the usual place of residence of the parent with return receipt requested and delivery restricted to the addressee, which means a postal employee may deliver the mail only to the authorized addressee. Time of delivery is considered to occur at noon on the next day on which regular mail delivery takes place after mailing.

History: En. Sec. 5, Ch. 469, L. 1995.

<General Materials (GM) - References, Annotations,  
or Tables>

MCA 50-20-205, **MT ST 50-20-205**

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
Notice is not required under 50-20-204 or 50-20-205 if:

(1) the attending physician certifies in the patient's medical record that a medical emergency exists and there is insufficient time to provide notice;

(2) notice is waived, in writing, by the person entitled to notice; or

(3) notice is waived under 50-20-212.

History: En. Sec. 6, Ch. 469, L. 1995.
MCA 50-20-209, MT ST 50-20-209

MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 20. ABORTION
PART 2. PARENTAL NOTICE OF ABORTION
ACT

50-20-209. Coercion prohibited

A parent, a guardian, or any other person may not coerce a minor to have an abortion. If a minor is denied financial support by the minor's parents, guardian, or custodian because of the minor's refusal to have an abortion, the minor must be considered an emancipated minor for the purposes of eligibility for public assistance benefits. The public assistance benefits may not be used to obtain an abortion.

History: En. Sec. 7, Ch. 469, L. 1995.

<MCA 50-20-209, MT ST 50-20-209>

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 20. ABORTION
PART 2. PARENTAL NOTICE OF ABORTION
ACT

50-20-211. Reports

A monthly report indicating the number of notices issued under this part and the number of times in which exceptions were made to the notice requirement under 50-20-208, as well as the type of exceptions, must be filed with the department of public health and human services on forms prescribed by the department. Patient names and other identifying information may not be used on the forms. The department shall prepare and make available to the public on an annual basis a compilation of the data reported.

History: En. Sec. 8, Ch. 469, L. 1995.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

Code Commissioner Change: Pursuant to sec. 3, Ch. 546, L. 1995, the Code Commissioner substituted Department of Public Health and Human Services for Department of Health and Environmental Sciences.

MCA 50-20-211, MT ST 50-20-211

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
(1) The requirements and procedures under this section are available to minors and incompetent persons whether or not they are residents of this state.

(2) (a) The minor or incompetent person may petition the youth court for a waiver of the notice requirement and may participate in the proceedings on the person's own behalf. The petition must include a statement that the petitioner is pregnant and is not emancipated. The court may appoint a guardian ad litem for the petitioner. A guardian ad litem is required to maintain the confidentiality of the proceedings. The youth court shall advise the petitioner of the right to court-appointed counsel and shall provide the petitioner with counsel upon request.

(b) If the petition filed under subsection (2)(a) alleges abuse as a basis for waiver of notice, the youth court shall treat the petition as a report under 41-3-202. The provisions of Title 41, chapter 3, part 2, apply to an investigation conducted pursuant to this subsection.

(3) Proceedings under this section are confidential and must ensure the anonymity of the petitioner. All proceedings under this section must be sealed. The petitioner may file the petition using a pseudonym or using the petitioner's initials. All documents related to the petition are confidential and are not available to the public. The proceedings on the petition must be given preference over other pending matters to the extent necessary to ensure that the court reaches a prompt decision. The court shall issue written findings of fact and conclusions of law and rule within 48 hours of the time that the petition is filed unless the time is extended at the request of the petitioner. If the court fails to rule within 48 hours and the time is not extended, the petition is granted and the notice requirement is waived.

(4) If the court finds by clear and convincing evidence that the petitioner is sufficiently mature to decide whether to have an abortion, the court shall issue an order authorizing the minor to consent to the performance or inducement of an abortion without the notification of a parent or guardian.

(5) The court shall issue an order authorizing the petitioner to consent to an abortion without the notification of a parent or guardian if the court finds, by clear and convincing evidence, that:

(a) there is evidence of a pattern of physical, sexual, or emotional abuse of the petitioner by one or both parents, a guardian, or a custodian; or

(b) the notification of a parent or guardian is not in the best interests of the petitioner.

(6) If the court does not make a finding specified in subsection (4) or (5), the court shall dismiss the petition.

(7) A court that conducts proceedings under this section shall issue written and specific findings of fact and conclusions of law supporting its decision and shall order that a confidential record of the evidence, findings, and conclusions be maintained.

(8) The supreme court may adopt rules providing an expedited confidential appeal by a petitioner if the youth court denies a petition. An order authorizing an abortion without notice is not subject to appeal.

(9) Filing fees may not be required of a pregnant minor who petitions a court for a waiver of parental notification or appeals a denial of a petition.
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 20. ABORTION
PART 2. PARENTAL NOTICE OF ABORTION

ACT 50-20-215. Criminal and civil penalties

(1) A person convicted of performing an abortion in violation of 50-20-204 or 50-20-205 shall be fined an amount not to exceed $500 or be imprisoned in the county jail for a term not to exceed 6 months, or both.

(2) Failure to provide the notice required under 50-20-204 or 50-20-205 is prima facie evidence in an appropriate civil action for a violation of a professional obligation. The evidence does not apply to issues other than failure to notify the parents or guardian. A civil action may be based on a claim that the failure to notify was the result of a violation of the appropriate legal standard of care. Failure to provide notice is presumed to be actual malice pursuant to the provisions of 27-1-221. This part does not limit the common-law rights of parents.

(3) A person who coerces a minor to have an abortion is guilty of a misdemeanor and upon conviction shall be fined an amount not to exceed $1,000 or be imprisoned in the county jail for a term not to exceed 1 year, or both. On a second or subsequent conviction, the person shall be fined an amount not less than $500 and not more than $50,000 and be imprisoned in the state prison for a term not less than 10 days and not more than 5 years, or both.

(4) A person not authorized to receive notice under 50-20-205 who signs a notice of waiver as provided in 50-20-208(2) is guilty of a misdemeanor.

History: En. Sec. 10, Ch. 469, L. 1995.
The right to perform an autopsy, dissect a human body, or make any postmortem examination involving dissection of any part of a body is limited to cases in which:

(1) specifically authorized by law;

(2) a coroner is authorized to hold an inquest and then only to the extent that the coroner may authorize dissection or autopsy;

(3) authorized by a written statement of the deceased, whether the statement is of a testamentary character or otherwise;

(4) authorized by the husband, wife, or next of kin responsible by law for burial to determine the cause of death and then only to the extent authorized;

(5) the decedent died in a hospital operated by the United States department of veterans affairs, Montana school for the deaf and blind, or an institution in the department of corrections or the department of public health and human services, leaving no surviving husband, wife, or next of kin responsible by law for burial and the manager or superintendent of the hospital or institution where death occurred obtains authority on order of the district court to determine the cause of death and then only to the extent authorized by court order;

(6) the decedent died in the state, was a resident, but left no surviving husband, wife, or next of kin charged by law with the duty of burial and the attending physician obtains authority on order of the district court for the purpose of ascertaining the cause of death and then only to the extent authorized by court order after it has been shown that the physician made diligent search for the next of kin responsible by law for burial.

An individual who has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brainstem, is dead. A determination of death must be made in accordance with accepted medical standards.

History: En. 69-7201 by Sec. 1, Ch. 228, L. 1977; R.C.M. 1947, 69-7201; amd. Sec. 1, Ch. 86, L. 1983.

Commissioner's Comment

[Section 1 of the Uniform Act (see compiler's comments to 1983 version -- 1980 Uniform Law)] provides comprehensive bases for determining death in all situations. It is based on a ten-year evolution of statutory language on this subject. The first statute passed in Kansas in 1970. In 1972, Professor Alexander Capron and Dr. Leon Kass refined the concept further in "A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal," 121 Pa.L.Rev. 87. In 1975, the Law and Medicine Committee of the American Bar Association (ABA) drafted a Model Definition of Death Act. In 1978, the National Conference of Commissioners on Uniform State Laws (NCCUSL) completed the Uniform Brain Death Act. It was based on the prior work of the ABA. In 1979, the American Medical Association (AMA) created its own Model Determination of Death statute. In the meantime, some twenty-five state legislatures adopted statutes based on one or another of the existing models.

The interest in these statutes arises from modern advances in lifesaving technology. A person may be artificially supported for respiration and circulation after all brain functions cease irreversibly. The medical profession, also, has developed techniques for determining loss of brain functions while cardiorespiratory support is administered. At the same time, the common law definition of death cannot assure recognition of these techniques. The common law standard for determining death is the cessation of all vital functions, traditionally demonstrated by "an absence of spontaneous respiratory and cardiac functions." There is, then, a potential disparity between current and accepted biomedical practice and the common law.

The proliferation of model acts and uniform acts, while indicating a legislative need, also may be confusing. All existing acts have the same principal goal--extension of the common law to include the new techniques for determination of death. With no essential disagreement on policy, the associations which have drafted statutes met to find common language. This Act contains that common language, and is the result of agreement between the ABA, AMA, and NCCUSL.

Part (1) codifies the existing common law basis for determining death--total failure of the cardiorespiratory system. Part (2) extends the common law to include the new procedures for determination of death based upon irreversible loss of all brain functions. The overwhelming majority of cases will continue to be determined according to part (1). When artificial means of support preclude a determination under part (1), the Act recognizes that death can be determined by the alternative procedures.

Under part (2), the entire brain must cease to function, irreversibly. The "entire brain" includes the brain stem, as well as the neocortex. The concept of "entire brain" distinguishes determination of death under this Act from "neocortical death" or "persistent vegetative state." These are not deemed valid medical or legal bases for determining death.

This Act also does not concern itself with living wills, death with dignity, euthanasia, rules on death certificates, maintaining life support beyond brain death in cases of pregnant women or of organ donors, and protection for the dead body. These subjects are left to other law.

This Act is silent on acceptable diagnostic tests and medical procedures. It sets the general legal standard for determining death, but not the medical criteria for doing so. The medical profession remains free to formulate acceptable medical practices and to utilize new biomedical knowledge, diagnostic tests,
It is unnecessary for the Act to address specifically the liability of persons who make determinations. No person authorized by law to determine death, who makes such a determination in accordance with the Act, should, or will be, liable for damages in any civil action or subject to prosecution in any criminal proceeding for his acts or the acts of others based on that determination. No person who acts in good faith, in reliance on a determination of death, should, or will be, liable for damages in any civil action or subject to prosecution in any criminal proceeding for his acts. There is no need to deal with these issues in the text of this Act.

Time of death, also, is not specifically addressed. In those instances in which time of death affects legal rights, this Act states the bases for determining death. Time of death is a fact to be determined with all others in each individual case, and may be resolved, when in doubt, upon expert testimony before the appropriate court.

Finally, since this Act should apply to all situations, it should not be joined with the Uniform Anatomical Gift Act so that its application is limited to cases of organ donation.

Commissioner's Comment to 1978 Uniform Act

[Section 1 of the Uniform Act (see compiler's comments to 1977 version -- 1978 Uniform Law)] legislates the concept of brain death. The Act does not preclude a determination of death under other legal or medical criteria, including the traditional criteria of cessation of respiration and circulation. Other criteria are practical in cases where artificial life-support systems are not utilized. Even those criteria are indicative of brain death.

"Functioning" is a critical word in the Act. It expresses the idea of purposeful activity in all parts of the brain, as distinguished from random activity. In a dead brain, some meaningless cellular processes, detectable by sensitive monitoring equipment, could create legal confusion if the word "activity" were substituted for "functioning".

Compiler's Comments

1983 Amendment: Substituted entire section (see 1983 Session Law) for "A human body with irreversible cessation of total brain function, as determined according to usual and customary standards of medical practice, is dead for all legal purposes."

The 1983 version of this section is an enactment of the Uniform Determination of Death Act (1980), drafted by the National Conference of Commissioners on Uniform State Laws.

The 1977 version of 50-22-101 was based on the Uniform Brain Death Act of the National Conference of Commissioners on Uniform State Laws, adopted in 1978. There were some differences, however, which can be seen readily by comparing the pre-1983 version of 50-22-101 (see Ch. 228, L. 1977) with the text of the Uniform Act:

"Section 1. [Brain Death.] For legal and medical purposes, an individual who has sustained irreversible cessation of all functioning of the brain, including the brain stem, is dead. A determination under this section must be made in accordance with reasonable medical standards.

Section 2. [Short Title.] This Act may be cited as the Uniform Brain Death Act."

Cross-References

Montana Rights of the Terminally Ill Act, Title 50, ch. 9.

Uniform Anatomical Gift Act, Title 72, ch. 17.

MCA 50-22-101, MT ST 50-22-101

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 33. BLOOD AND BLOOD PRODUCTS
PART I. GENERAL PROVISIONS

50-33-102. Furnishing of blood, blood products, and human tissue, organs, or bones declared service and not sale

The furnishing of and the injecting, transfusing, transplanting, or transferring into the human body of whole blood, plasma, blood products, blood derivatives, human tissue, organs, or bones by a hospital, long-term care facility, or doctor of any such substances obtained from any source which said hospital, long-term care facility, or doctor is not directly or indirectly financially interested in or has any control over is hereby declared not to be a sale of such whole blood, plasma, blood products, blood derivatives, human tissue, organs, or bones for any purpose.

History: En. Sec. 1, Ch. 284, L. 1971; amd. Sec. 1, Ch. 76, L. 1975; R.C.M. 1947, 69-2203(part); amd. Sec. 1, Ch. 401, L. 1987.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

1987 Amendment: In two places, after "derivatives", inserted "human tissue, organs, or bones"; and in first sentence, after "transfusing", inserted "transplanting, or transferring".

Cross-References

Sale as defined in Uniform Commercial Code, 30-2-106.

MCA 50-33-102, MT ST 50-33-102

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT

MONTANA CODE ANNOTATED
TITLE 50. HEALTH AND SAFETY
CHAPTER 33. BLOOD AND BLOOD PRODUCTS
PART 1. GENERAL PROVISIONS

50-33-103. Immunity of physicians and hospitals

No physician, long-term care facility, or hospital may be held liable, in the absence of fault or negligence on the part of such a hospital, long-term care facility, or doctor, for injuries resulting from the furnishing or performing of such services.

History: En. Sec. 1, Ch. 284, L. 1971; amd. Sec. 1, Ch. 76, L. 1975; R.C.M. 1947, 69-2203(part).

NOTES, REFERENCES, AND ANNOTATIONS

Cross-References

Liability, Title 27, ch. 1, part 7.

Good Samaritan law, 27-1-714.

Validity of consent to medical treatment, Title 41, ch. 1, part 4.

MCA 50-33-103, MT ST 50-33-103

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
(1) (a) There is a grant program established within the department for the allocation of grant money to local child-care resource and referral programs and for improving the availability of quality child care and school-age day care.

(b) Program funds may include money from the following sources:

(i) funds specifically appropriated by the legislature for use under this section;

(ii) private gifts, grants, and donations;

(iii) federal or foundation grants awarded to the state for the purposes of this section; and

(iv) any other money made available for the purposes of this section.

(2) (a) The department may award grants to private, nonprofit organizations and public organizations that demonstrate the ability to provide child-care resource and referral services.

(b) To be eligible for a grant from the department as a resource and referral agency for a local area, an organization:

(i) shall maintain a database of child-care services in the community, including day-care facilities and preschools, which the organization continually updates;

(ii) shall include on the staff of the organization at least one individual who has expertise in child development;

(iii) must have the capability to provide resource and referral services in the local area;

(iv) must be able to respond to requests for information or assistance in a timely fashion;

(v) must be committed to providing services to all segments of the general public;

(vi) must be able to provide parents with a checklist to identify quality child-care services;

(vii) must be able to provide information on the availability of child-care subsidies;

(viii) shall maintain and make available to the public the number of all referrals made by the resource and referral agency; and

(ix) shall otherwise satisfy regulations promulgated by the department pursuant to this part.

(3) (a) The department may award grants for improving the availability of quality child care and school-age day care and for consumer education.

(b) The following grant applications must be given priority:

(i) grant applications for professional training for day-care or school-age care providers;

(ii) grant applications for the startup of school-age care programs or facilities when a community need has been demonstrated;

(iii) grant applications for consumer education; and

(iv) grant applications for preservation or expansion of existing care programs that fill a demonstrated need.

(4) The department shall adopt rules to administer the provisions of this section.

History: En. Sec. 5, Ch. 692, L. 1989; amd. Sec. 2, Ch. 318, L. 1997.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

1997 Amendment: Chapter 318 in (1)(a), at end, inserted "and for improving the availability of quality child care and school-age day care"; inserted (1)(b) stating that program funds may be from legislative appropriations; private gifts, grants, and donations; federal or foundation grants; and any other source; inserted (3) allowing Department grants to increase
availability of quality child care and school-age day care and for consumer education and establishing a priority for grant awards; inserted (4) requiring Department rules; and made minor changes in style. Amendment effective April 21, 1997.

Preamble: The preamble attached to Ch. 318, L. 1997, provided: "WHEREAS, the "traditional" American family with the father working and the mother at home to care for the children now constitutes only 25% of all American families; and

WHEREAS, an estimated 40,000 of 70,000 Montana children under 6 years of age need child care, while only about 25,000 licensed or registered child-care slots are available; and

WHEREAS, a shortage of before- and after-school programs for school-age children places children at risk for delinquency and teen pregnancy; and

WHEREAS, the availability of day care is critical to the success of welfare-to-work programs; and

WHEREAS, high-quality care is essential to the healthy development of Montana's children, and professional training for child-care providers is the single most effective way to ensure quality care; and

WHEREAS, funding limitations prevent many child-care providers from starting day-care or school-age care businesses and from obtaining professional training."

1997 Statement of Intent: The statement of intent attached to Ch. 318, L. 1997, provided: "A statement of intent is required for this bill because 52-2-711, as amended, directs the department of public health and human services to adopt rules to administer the grant program. It is the intent of the legislature that grant awards be consistent with the legislative priorities set forth in this bill and that additional grants be consistent with the state child-care plan as developed by the child-care advisory council. The department is encouraged to also adopt rules that will formally provide for an advisory task force as previously used to advise the department on grant awards."

Saving Clause: Section 3, Ch. 318, L. 1997, was a saving clause.

Repeal of Termination: Section 18, Ch. 692, L. 1989, which terminated this section June 30, 1991, was repealed by sec. 1, Ch. 618, L. 1991.

Effective Date: Section 17, Ch. 692, L. 1989, provided that this section is effective May 19, 1989.

MCA 52-2-711, MT ST 52-2-711
Current through the 2005 Regular Session of the 59th Legislature
END OF DOCUMENT
52-3-811. Reports

(1) When the professionals and other persons listed in subsection (3) know or have reasonable cause to suspect that an older person or a person with a developmental disability known to them in their professional or official capacities has been subjected to abuse, sexual abuse, neglect, or exploitation, they shall:

(a) if the person is not a resident of a long-term care facility, report the matter to:
   (i) the department or its local affiliate; or
   (ii) the county attorney of the county in which the person resides or in which the acts that are the subject of the report occurred;

(b) if the person is a resident of a long-term care facility, report the matter to the long-term care ombudsman appointed under the provisions of 42 U.S.C. 3027(a)(12) and to the department. The department shall investigate the matter pursuant to its authority in 50-5-204 and, if it finds any allegations of abuse, sexual abuse, neglect, or exploitation contained in the report to be substantially true, forward a copy of the report to the county attorney as provided in subsection (1)(a)(ii).

(2) If the report required in subsection (1) involves an act or omission of the department that may be construed as abuse, sexual abuse, neglect, or exploitation, a copy of the report may not be sent to the department but must be sent instead to the county attorney of the county in which the older person or the person with a developmental disability resides or in which the acts that are the subject of the report occurred.

(3) Professionals and other persons required to report are:

(a) a physician, resident, intern, professional or practical nurse, physician assistant, or member of a hospital staff engaged in the admission, examination, care, or treatment of persons;

(b) an osteopath, dentist, denturist, chiropractor, optometrist, podiatrist, medical examiner, coroner, or any other health or mental health professional;

(c) an ambulance attendant;

(d) a social worker or other employee of the state, a county, or a municipality assisting an older person or a person with a developmental disability in the application for or receipt of public assistance payments or services;

(e) a person who maintains or is employed by a roominghouse, retirement home or complex, nursing home, group home, adult foster care home, adult day-care center, or assisted living facility or an agency or individual that provides home health services or personal care in the home;

(f) an attorney, unless the attorney acquired knowledge of the facts required to be reported from a client and the attorney-client privilege applies;

(g) a peace officer or other law enforcement official;

(h) a person providing services to an older person or a person with a developmental disability pursuant to a contract with a state or federal agency; and

(i) an employee of the department while in the conduct of the employee's duties.

(4) Any other persons or entities may, but are not required to, submit a report in accordance with subsection (1).

History: En. Sec. 4, Ch. 623, L. 1983; amd. Sec. 13, Ch. 548, L. 1985; amd. Sec. 11, Ch. 609, L. 1987; amd. Sec. 5, Ch. 198, L. 1989; Sec. 53-5-511, MCA 1989; redes. 52-3-811 by Code Commissioner, 1991; amd. Sec. 5, Ch. 167, L. 1993; amd. Sec. 3, Ch. 421, L. 1993; amd. Sec. 154, Ch. 418, L. 1995; amd. Sec. 7, Ch. 465, L. 1995; amd. Sec. 365, Ch. 546, L. 1995; amd. Sec. 4, Ch. 196, L. 1999; amd. Sec. 9, Ch. 54, L. 2003.

NOTES, REFERENCES, AND ANNOTATIONS
Compiler's Comments

2003 Amendment: Chapter 54 in (3)(e) near middle after "day-care center, or" substituted "assisted living" for "personal-care". Amendment effective October 1, 2003.

1999 Amendment: Chapter 196 in (3)(e) after "retirement home" inserted "or complex" and after "adult foster care home" inserted language regarding entity or individual who provides home health services or personal care in the home; inserted (3)(i) regarding employee of department; in (4) inserted "entities"; and made minor changes in style. Amendment effective October 1, 1999.

1995 Amendments -- Instructions to Code Commissioner: Chapter 418 in (1)(b), at end of first sentence, substituted "department of public health" for "department of health and environmental sciences". Amendment effective July 1, 1995.

In (1), (2), (3)(d), and (3)(h) the Code Commissioner changed "developmentally disabled person" to "person with a developmental disability" pursuant to sec. 7, Ch. 465, L. 1995, directing the Code Commissioner to make the change in Title 52, ch. 3, part 8. Amendment effective April 14, 1995.

Chapter 546 in (1)(a)(i) and (2) substituted "department of public health and human services" for "department of family services"; in (1)(b), at end of first sentence after "department", deleted "of health and environmental sciences" and near end of second sentence, after "report", deleted "to the department of family services and"; and made minor changes in style. Amendment effective July 1, 1995.

Transition: Section 499, Ch. 418, L. 1995, provided: "The provisions of 2-15-131 through 2-15-137 apply to [this act]."

Saving Clauses: Section 503, Ch. 418, L. 1995, was a saving clause.

Section 571, Ch. 546, L. 1995, was a saving clause.


Chapter 421 inserted (3)(h) concerning persons providing services to older persons under a contract; and made minor changes in style.

1989 Amendment: Near beginning of (1) inserted "or a developmentally disabled person"; near beginning of (1)(a), (1)(a)(ii), and (1)(b), before "person", deleted "older"; near end of (2), after "older person", inserted "or the developmentally disabled person"; and in middle of (3)(d) inserted "or a developmentally disabled person". Amendment effective March 21, 1989.

1987 Amendment: Substituted "department of family services" for "department of social and rehabilitation services".

1985 Amendment: In (3)(b) after "dentist", inserted "denturist".

Cross-References

Office of County Attorney, Title 7, ch. 4, part 27.

Local government law enforcement, Title 7, ch. 32.

Licensing of medical doctors, Title 37, ch. 3.

Licensing of social workers, Title 37, ch. 22.

Long-term care facilities -- licensing, Title 50, ch. 5, part 2.

Local offices of public assistance, Title 53, ch. 2, part 3.

Law Review Articles


MCA 52-3-811, MT ST 52-3-811

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
(1) The report required by 52-3-811 may be made in writing or orally, by telephone or in person. A person who receives an oral report shall prepare it in writing as soon as possible.

(2) The report referred to under this section must contain:

   (a) the names and addresses of the older person or the person with a developmental disability and the person, if any, responsible for that person's care;

   (b) the name and address, if available, of the person who is alleged to have abused, sexually abused, neglected, or exploited the older person or the person with a developmental disability;

   (c) to the extent known, the person's age and the nature and extent of the abuse, sexual abuse, neglect, or exploitation, including any evidence of previous injuries, abuse, sexual abuse, neglect, or exploitation sustained by the older person or the person with a developmental disability and any evidence of prior instances of abuse, sexual abuse, neglect, or exploitation of other older persons or persons with developmental disabilities committed by the person alleged to have committed abuse, sexual abuse, neglect, or exploitation; and

   (d) the name and address of the person making the report.

History: En. Sec. 5, Ch. 623, L. 1983; amd. Sec. 6, Ch. 198, L. 1989; Sec. 53-5-512, MCA 1989; redes. 52-3-812 by Code Commissioner, 1991; amd. Sec. 6, Ch. 167, L. 1993; amd. Sec. 7, Ch. 465, L. 1995; amd. Sec. 5, Ch. 196, L. 1999.

<General Materials (GM) - References, Annotations, or Tables>
MCA 53-19-402, MT ST 53-19-402

West's Montana Code Annotated Currentness
Title 53. Social Services and Institutions
* Chapter 19, Physically Disabled
* Part 4, Newborn Hearing Screening

53-19-402. Statewide universal newborn hearing screening, tracking, and intervention program

(1) There is a universal newborn hearing screening program in the department of public health and human services. The department shall implement the program to ensure a hearing screening test for all newborn infants for identification of newborn infant hearing loss. The department shall implement the program to ensure newborn hearing screening tests are completed before discharge from a hospital or no later than 1 month after birth.

(2) The department shall adopt rules to:

(a) ensure that each licensed hospital, health care facility, or health care provider providing obstetric services:

(i) complete newborn hearing screenings for all infants before discharge or no later than 1 month after birth and report the results to each infant's primary care provider, including any recommendation for audiologic assessment for an infant with two failed hearing screenings; and

(ii) provide required education regarding hearing screenings and hearing loss;

(b) ensure monitoring of all babies screened in Montana and referred for audiologic assessment to ensure that they receive an audiologic assessment by 3 months of age;

(c) establish newborn hearing screening protocols that are objective and physiologically based;

(d) establish education protocols;

(e) establish reporting requirements that are related to newborn infant hearing screening, recommendation for audiologic assessment, and audiologic assessment results; and

(f) ensure the electronic sharing of audiologic evaluation information of infants diagnosed as deaf or hard-of-hearing with the Montana school for the deaf and blind, pursuant to the school's responsibility for intervention tracking as provided in 20-8-102.

(3) The department shall assist each licensed hospital, health care facility, or health care provider providing obstetric services in developing systems for reporting and in accessing funds to purchase hearing screening equipment by providing information on funding sources known to the department.

(4) The department may accept contributions, gifts, grants, or endowments from public or private sources for the use and benefit of this program.


ADMINISTRATIVE CODE REFERENCES

Definitions, see MT ADC 37.57.401.

Newborn hearing screening education, see MT ADC 37.57.403.

Newborn hearing screening protocols--Hospitals and health care facilities, see MT ADC 37.57.407.

Reporting newborn hearing screening results--Parents--Primary care providers, see MT ADC 37.57.410.

Reporting to the department regarding newborn hearing screening and education, see MT ADC 37.57.413.

LIBRARY REFERENCES

Health 350.
Westlaw Key Number Search: 198Hk350.
C.J.S. Health and Environment §§ 1 to 2, 70.

MCA 53-19-402, MT ST 53-19-402

Current through all 2009 legislation

(1) Each licensed hospital, health care facility, or health care provider that provides obstetric services shall provide education to parents of infants born in the hospital or health care facility of the importance of screening the hearing of newborn infants and providing followup care.

(2) Every licensed hospital or health care facility that provides obstetric services shall:

(a) perform newborn hearing screenings, including screening of infants transferred into the hospital or health care facility from another hospital or health care facility, unless the transferring facility has already performed the screening;

(b) report monthly to the department the following information:

(i) the infants born in the hospital or born outside of the hospital and transported or transferred to the hospital or health care facility;

(ii) the infants screened, including those infants born outside of the hospital or health care facility and transported or transferred to it from another hospital or health care facility or screened as part of a cooperative agreement with health care providers providing obstetric services in their service area;

(iii) the infants not screened and the reason each infant was not screened, in accordance with reporting requirements;

(iv) the infants who passed the screening; and

(v) the infants who do not pass their screenings and the contact information for the primary care provider who was notified of the screening results for each infant who did not pass the screenings.

(3) Every licensed audiologist performing audiologic evaluations of infants identified by hearing screening as needing audiologic assessment shall report monthly to the department the following information:

(a) the identity of infants referred to them for audiologic assessment;

(b) the referring person or health care facility;

(c) the birthing facility in which the infant was born; and

(d) the results of the audiologic assessment of each infant referred to them.


ADMINISTRATIVE CODE REFERENCES

Definitions, see MT ADC 37.57.401.

Newborn hearing screening education, see MT ADC 37.57.403.

Newborn hearing screening protocols--Hospitals and health care facilities, see MT ADC 37.57.407.

Reporting newborn hearing screening results--Parents--Primary care providers, see MT ADC 37.57.410.

Reporting to the department regarding newborn hearing screening and education, see MT ADC 37.57.413.

MCA 53-19-404, MT ST 53-19-404

Current through all 2009 legislation

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As used in this part, the following definitions apply:

(1) "Abuse" means any willful, negligent, or reckless mental, physical, sexual, or verbal mistreatment or maltreatment or misappropriation of personal property of any person receiving treatment in a mental health facility that insults the psychosocial, physical, or sexual integrity of any person receiving treatment in a mental health facility.

(2) "Behavioral health inpatient facility" means a licensed facility of 16 beds or less designated by the department that:

(a) may be a freestanding licensed hospital or a distinct part of another licensed hospital and that is capable of providing inpatient psychiatric services, including services to persons with mental illness and co-occurring chemical dependency; and

(b) has contracted with the department to provide services to persons who have been involuntarily committed for care and treatment of a mental disorder pursuant to this title.

(3) "Board" or "mental disabilities board of visitors" means the mental disabilities board of visitors created by 2-15-211.

(4) "Commitment" means an order by a court requiring an individual to receive treatment for a mental disorder.

(5) "Court" means any district court of the state of Montana.

(6) "Department" means the department of public health and human services provided for in 2-15-2201.

(7) "Emergency situation" means a situation in which any person is in imminent danger of death or bodily harm from the activity of a person who appears to be suffering from a mental disorder and appears to require commitment.

(8) "Friend of respondent" means any person willing and able to assist a person suffering from a mental disorder and requiring commitment or a person alleged to be suffering from a mental disorder and requiring commitment in dealing with legal proceedings, including consultation with legal counsel and others. The friend of respondent may be the next of kin, the person's conservator or legal guardian, if any, representatives of a charitable or religious organization, or any other person appointed by the court to perform the functions of a friend of respondent set out in this part. Only one person may at any one time be the friend of respondent within the meaning of this part. In appointing a friend of respondent, the court shall consider the preference of the respondent. The court may at any time, for good cause, change its designation of the friend of respondent.

(9) (a) "Mental disorder" means any organic, mental, or emotional impairment that has substantial adverse effects on an individual's cognitive or volitional functions.

(b) The term does not include:

(i) addiction to drugs or alcohol;

(ii) drug or alcohol intoxication;

(iii) mental retardation; or

(iv) epilepsy.

(c) A mental disorder may co-occur with addiction or chemical dependency.

(10) "Mental health facility" or "facility" means the state hospital, the Montana mental health nursing care center, or a hospital, a behavioral health inpatient facility, a mental health center, a residential treatment facility, or a residential treatment center licensed or certified by the department that provides treatment to children or adults with a mental disorder. A correctional institution or facility or jail is not a mental health facility within the meaning of this part.

(11) "Mental health professional" means:

(a) a certified professional person;
(b) a physician licensed under Title 37, chapter 3;

(c) a professional counselor licensed under Title 37, chapter 23;

(d) a psychologist licensed under Title 37, chapter 17;

(e) a social worker licensed under Title 37, chapter 22; or

(f) an advanced practice registered nurse, as provided for in 37-8-202, with a clinical specialty in psychiatric mental health nursing.

(12) (a) "Neglect" means failure to provide for the biological and psychosocial needs of any person receiving treatment in a mental health facility, failure to report abuse, or failure to exercise supervisory responsibilities to protect patients from abuse and neglect.

(b) The term includes but is not limited to:

(i) deprivation of food, shelter, appropriate clothing, nursing care, or other services;

(ii) failure to follow a prescribed plan of care and treatment; or

(iii) failure to respond to a person in an emergency situation by indifference, carelessness, or intention.

(13) "Next of kin" includes but is not limited to the spouse, parents, adult children, and adult brothers and sisters of a person.

(14) "Patient" means a person committed by the court for treatment for any period of time or who is voluntarily admitted for treatment for any period of time.

(15) "Peace officer" means any sheriff, deputy sheriff, marshal, police officer, or other peace officer.

(16) "Professional person" means:

(a) a medical doctor;

(b) an advanced practice registered nurse, as provided for in 37-8-202, with a clinical specialty in psychiatric mental health nursing; or

(c) a person who has been certified, as provided for in 53-21-106, by the department.

(17) "Reasonable medical certainty" means reasonable certainty as judged by the standards of a professional person.

(18) "Respondent" means a person alleged in a petition filed pursuant to this part to be suffering from a mental disorder and requiring commitment.

(19) "State hospital" means the Montana state hospital.

History: Ap. p. 38-1302 by Sec. 2, Ch. 466, L. 1975; amd. Sec. 9, Ch. 37, L. 1977; amd. Sec. 2, Ch. 546, L. 1977; Sec. 38-1302, R.C.M. 1947; (15)En. 38-106.1 by Sec. 3, Ch. 120, L. 1974; Sec. 38-106.1, R.C.M. 1947; R.C.M. 1947, 38-106.1, 38-1302; amd. Sec. 1, Ch. 547, L. 1979; amd. Sec. 18, Ch. 361, L. 1983; amd. Sec. 1, Ch. 578, L. 1983; amd. Sec. 1, Ch. 376, L. 1987; amd. Sec. 1, Ch. 262, L. 1991; amd. Sec. 1, Ch. 312, L. 1993; amd. Sec. 486, Ch. 546, L. 1995; amd. Sec. 15, Ch. 490, L. 1997; amd. Sec. 2, Ch. 310, L. 2001; amd. Sec. 6, Ch. 342, L. 2001; amd. Sec. 2, Ch. 344, L. 2001; amd. Sec. 3, Ch. 513, L. 2003; amd. Sec. 1, Ch. 81, L. 2005.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

2005 Amendment: Chapter 81 in definition of mental disorder inserted (c) concerning co-occurrence with addiction or chemical dependency. Amendment effective October 1, 2005.

2003 Amendment: Chapter 513 inserted definition of behavioral health inpatient facility; in definition of mental health facility or facility before "mental health center" inserted "a behavioral health inpatient facility"; and made minor changes in style. Amendment effective July 1, 2003.

Severability: Section 10, Ch. 513, L. 2003, was a severability clause.

2001 Amendments -- Composite Section: Chapter 310 in definition of professional person inserted (b) relating to an advanced practice registered nurse with a clinical specialty in psychiatric mental health nursing.
psychiatric mental health nursing; and made minor changes in style. Amendment effective October 1, 2001.

Chapter 342 inserted definition of mental health professional; and made minor changes in style. Amendment effective October 1, 2001.

Chapter 344 inserted definition of abuse; in definition of mental health facility or facility substituted language in first sentence that term means state hospital, Montana mental health nursing care center, or hospital, mental health center, residential treatment facility, or residential treatment center licensed or certified that provides treatment to children or adults with mental disorder for former language that read: "a public hospital or a licensed private hospital that is equipped and staffed to provide treatment for persons with mental disorders or a community mental health center or any mental health clinic or treatment center approved by the department"; inserted definition of neglect; and made minor changes in style. Amendment effective October 1, 2001.

1997 Amendment: Chapter 490 inserted definition of commitment; in definition of emergency situation, after "death or", deleted "serious" and at end substituted "suffering from a mental disorder and appears to require commitment" for "seriously mentally ill"; in definition of friend of respondent, in first sentence after "assist a", deleted "seriously mentally ill", after second "person" inserted "suffering from a mental disorder and requiring commitment", and after "alleged to be" substituted "suffering from a mental disorder and requiring commitment" for "seriously mentally ill"; in definition of mental disorder inserted (c) regarding mental retardation and (d) regarding epilepsy; in definition of respondent, at end, substituted "suffering from a mental disorder and requiring commitment" for "seriously mentally ill"; deleted definition of seriously mentally ill that read: ""Seriously mentally ill" means suffering from a mental disorder which has resulted in self-inflicted injury or injury to others or the imminent threat of injury or which has deprived the person afflicted of the ability to protect the person's life or health. For this purpose, injury means physical injury. A person may not be involuntarily committed to a mental health facility or detained for evaluation and treatment because the person is an epileptic, mentally deficient, mentally retarded, senile, or suffering from a mental disorder unless the condition causes the person to be seriously mentally ill within the meaning of this part"; and made minor changes in style. Amendment effective July 1, 1997.

Saving Clause: Section 40, Ch. 490, L. 1997, was a saving clause.

1995 Amendment: Chapter 546 in definition of Department substituted "department of public health and human services provided for in 2-15-2201" for "department of corrections and human services provided for in Title 2, chapter 15, part 23". Amendment effective July 1, 1995.

Saving Clause: Section 571, Ch. 546, L. 1995, was a saving clause.

1993 Amendment: Chapter 312 in definition of mental disorder added exceptions for addiction and intoxication; and made minor changes in style. Amendment effective July 1, 1993.

1991 Amendment -- Instructions to Code Commissioner: The Code Commissioner changed "department of institutions" to "department of corrections and human services", pursuant to sec. 1, Ch. 262, L. 1991, directing the Code Commissioner to make the change wherever necessary in the Montana Code Annotated. Amendment effective July 1, 1991.

1987 Amendment: Inserted (5) and deleted former (13), each defining friend of respondent, but (13) related only to a person who was or was alleged to be seriously mentally ill; inserted definition of mentally ill; in (14) inserted "mentally ill or"; and made minor changes in phraseology.

1983 Amendments: Chapter 361, in definition of state hospital, substituted "Montana state hospital" for "Warm Springs state hospital".

Chapter 578 in definition of professional person, after "a person", substituted "who has been certified, as provided for in 53-21-106, by the department" for "trained in the field of mental health and certified by the department in accordance with standards of professional licensing boards, federal regulations, and the joint commission on accreditation of hospitals".

Instructions to Code Commissioner: Section 14, Ch. 547, L. 1979, provided: "All references to "responsible person" in Title 53, chapter 21, shall be changed to "friend of respondent" by the Code Commissioner."
Section Not Codified: Section 38-121, R.C.M. 1947, a section changing to "of unsound mind" all like references, was not codified in the MCA. Citation may be made to sec. 1, Ch. 376, L. 1973.

Administrative Rules

ARM 37.91.106 Definitions.

Case Notes

Res Judicata Inapplicable to Involuntary Commitment Hearing -- Criterion of " Seriously Mentally Ill" Only Issue: L.B. was examined by a professional person and determined to suffer from a serious mental disorder (see 1997 amendment) that required treatment. Following presentation of the professional's testimony at a hearing for involuntary commitment, the District Court held that the testimony was too speculative and ordered L.B. released. After the hearing, L.B. was detained by the Sheriff's office for a short time in an attempt to find a place for him, rather than just sending him out onto the streets. During his detention, L.B. was examined by a second professional person who determined that L.B. should be involuntarily committed to the state hospital for immediate treatment, and a second petition for commitment was filed that same day. The District Court subsequently determined that L.B.'s mental illness deprived him of the ability to protect his life or health and transferred him to the state hospital for treatment. L.B. argued that the doctrine of res judicata barred consideration of the second petition. However, the District Court expressly prohibited the introduction of evidence relating to the time period prior to the first hearing; therefore, the issues were not the same in the second hearing, nor could the first order releasing L.B. be considered final and subject to res judicata. The question of whether an individual is seriously mentally ill may be brought at any time as long as the necessary statutory criteria are met. A finding at one time that an individual does not suffer from a serious mental illness (see 1997 amendment) is not intended to be a final and irrevocable decision on the individual's mental health. In re Mental Health of L.C.B., 253 M 1, 830 P2d 1299, 49 St. Rep. 290 (1992).

Standard of Proof for Involuntary Commitment - - Finding of Seriously Mentally Ill Upheld: The parents of G.P. filed a request with the Yellowstone County Attorney to have their son involuntarily committed. G.P. was evaluated by a psychiatrist who testified at the commitment hearing that G.P. was "beyond a reasonable doubt seriously mentally ill as defined in section 53-21-102, MCA" (see 1997 amendment). G.P. was committed and, on appeal, challenged the District Court finding that he was seriously mentally ill, rather than only mentally ill, claiming that there was no proof of overt acts. The Supreme Court held that overt acts are only necessary to prove serious mental illness based on "self-inflicted injury or injury to others or the imminent threat thereof" but not necessary to prove serious mental illness based on a respondent "suffering from a mental disorder . . . which has deprived the person afflicted of the ability to protect his life or health" as provided under this section. The Supreme Court noted that the psychiatrist testified that G.P. suffered from auditory hallucinations that directed him to do things that he could not control, that G.P.'s roommate testified that G.P. refused to take his medicine and denied that he needed medicine, and that G.P.'s parents testified that G.P. ate very little. The Supreme Court found that this evidence satisfied the standard in 53-21-126(2) because it indicated that G.P.'s illness was interrupting his cognitive process and causing delusional thinking, which condition rendered him unable to protect his own life or health. In re G.P., 246 M 195, 806 P2d 3, 47 St. Rep. 1840 (1990).

Adequate Medical Care Not Basis for Disregarding Due Process: The medical center, in which the respondent was placed by the officers who picked her up, did not follow proper procedure, and the respondent was held without authority for 5 days before her competency hearing. The Supreme Court held that providing adequate medical care is not a basis for disregarding the due process and statutory rights of a person charged with being seriously mentally ill (see 1997 amendment). The court went on to admonish the medical center, the County Attorney's office, and the county family services department for their failure to comply with the due process rights of the respondent. Mental Health of E.P., 241 M 316, 787 P2d 322, 47 St. Rep. 297 (1990).

Finding of Mental Illness Supported by Overwhelming Evidence: The lower court found that the evidence demonstrated that the respondent was totally unable to take care of herself. The Supreme Court stated that after reviewing the record, it found that there was overwhelming evidence to support the lower court's finding. Mental Health of E.P., 241 M 316, 787 P2d 322, 47 St. Rep. 297 (1990).

"Seriously Mentally Ill" -- Supporting Evidence: Patient, appealing the order for his involuntary
commitment to the state mental hospital, suffered from chronic paranoid schizophrenia that caused him to become angry and hostile when his delusions were challenged. Evidence showed he owned and carried weapons. There was sufficient evidence on which the court could base a finding of serious mental illness (see 1997 amendment). The statute does not require a court to wait until a person actually uses a weapon against another person before finding him seriously mentally ill. In re Mental Health of R.J.W., 226 M 419, 736 P2d 110, 44 St. Rep. 770 (1987).

Sufficient evidence supported an order of involuntary commitment when evidence presented at trial indicated the following: (1) respondent had exhibited violent behavior in the past; (2) his sister felt threatened by him on an occasion when he entered her home and demanded the keys to her car; (3) for no apparent reason, respondent entered the home of a family whom he did not know; and (4) a psychologist testified that respondent lacked ability to care for himself and posed a threat to others. In re D.B., 218 M 467, 709 P2d 161, 42 St. Rep. 1747 (1985).

A man who was hospitalized when police found him driving his car around in circles in a field and spouting "religious ideation", who told a nurse that he felt "like killing anybody and anyone in sight", who refused to take his prescribed medication, and who had been hospitalized five times previously when he refused medication was "seriously mentally ill" within the meaning of this statute (see 1997 amendment). There was sufficient evidence that commitment to Montana State Hospital at Warm Springs was the least restrictive form of commitment. The order of the District Court was affirmed. In re J.B., 217 M 504, 705 P2d 598, 42 St. Rep. 1335 (1985).

A woman who jumped out of a moving car with the intent to kill herself was "seriously mentally ill" within the meaning of this section (see 1997 amendment). In re the Mental Health of A.G., 208 M 366, 677 P2d 592, 41 St. Rep. 406 (1984).

There was sufficient evidence to support the conclusion that respondent was "seriously mentally ill" (see 1997 amendment) beyond a reasonable doubt, and respondent failed to overcome the burden of providing proof to the contrary; hence, extended detention was warranted. In re Sonsteng, 175 M 307, 573 P2d 1149 (1977); In re Miller, 175 M 318, 573 P2d 1155 (1977).

Suicidal Threats Constituting Emergency Situation: Threats to kill oneself as well as others, angry and abusive conduct toward others, a state of depression lasting a period of a week, and evidence of a previous suicide attempt 2 months earlier clearly indicated an emergency situation warranting detention under 53-21-129. Reiser v. Prunty, 224 M 1, 727 P2d 538, 43 St. Rep. 1967 (1986).

Detention Prior to Court Finding of Serious Mental Illness -- Determination by Professional Person Rather Than Peace Officer: Appellant, M.C., argued that under 53-21-129, the peace officer makes the initial decision on whether an emergency situation exists and that in this case the officer did not make that decision. M.C. also contended that the evidence was insufficient to hold him on an emergency basis. The Supreme Court held that 53-21-129 merely permits the officer to take a person into custody for an evaluation. It does not give the officer authority to decide whether the person should be placed in emergency detention; rather, the professional person determines whether the person is seriously mentally ill (see 1997 amendment) and should be placed in emergency detention. Once that determination is made, it constitutes sufficient evidence that the person may be detained. In re M.C., 220 M 437, 716 P2d 203, 43 St. Rep. 508 (1986).

Stipulation to Commitment -- Montana State Hospital as Least Restrictive Environment: The appellant, M.C., argued on appeal that evidence was insufficient to warrant his transfer to Montana State Hospital. At a commitment hearing, the District Court heard evidence on M.C.'s inability to cooperate in treatment at the Billings Mental Health Center, as well as testimony from a Center doctor indicating that Montana State Hospital was the least restrictive environment in which M.C. could receive the care and supervision he needed. After the hearing, M.C. and his counsel stipulated to, and the District Court ordered, a commitment to the Billings Mental Health Center or "another mental health facility in Montana". The Supreme Court held this evidence to be sufficient to support the District Court's action in committing M.C. to the Montana State Hospital. In re M.C., 220 M 437, 716 P2d 203, 43 St. Rep. 508 (1986).

Certified Professional's Testimony -- Sufficient to Support Finding of Mental Disorder: J.M.'s cousin requested the Yellowstone County Attorney to petition that J.M. be declared seriously mentally ill (see 1997 amendment) and be committed to a mental health facility. Pursuant to 53-21-122, the District
Court appointed a certified mental health professional to evaluate J.M. J.M. was uncooperative in responding to questions from the certified professional. Because of J.M.'s uncooperative attitude, the professional observed J.M. on only two occasions and relied on reports from other people concerning J.M. At the commitment hearing, the professional testified that J.M. was seriously mentally ill (see 1997 amendment) and set forth the data for making the diagnosis, the characteristics of J.M.'s particular disorder, and the effect of the disorder on J.M. The testimony was sufficient to establish that J.M. was suffering from a mental disorder. In re J.M., 217 M 300, 704 P2d 1037, 42 St. Rep. 1212 (1985).

Commitment Procedural Safeguards Ignored: The State failed to follow the commitment procedural safeguards in handling Shennum's commitment. The record does not evidence the existence of an emergency situation sufficient to invoke 53-21-129. Shennum was not advised of his constitutional rights before a medical examination incorrectly obtained under a purported emergency situation. Absent an emergency, it was the duty of the County Attorney to proceed in accordance with 53-21-121 through 53-21-126 in order to commit Shennum as a seriously mentally ill (see 1997 amendment) person. Several of the procedural protections contained in those sections were ignored. Therefore, the initial commitment was reversed with guidelines for the State to proceed properly in further commitment proceedings. In re Shennum, 210 M 442, 684 P2d 1073, 41 St. Rep. 1148 (1984).

Evidence Insufficient for Involuntary Commitment: Testimony at trial did not clearly and convincingly establish that respondent, due to his mental condition, was unable to protect his life or health at the time of the trial. Therefore, the evidence that respondent was "seriously mentally ill" within the meaning of 53-21-102 (see 1997 amendment) was insufficient as a matter of law, and the District Court commitment order was vacated. In re R.T., 204 M 493, 665 P2d 789, 40 St. Rep. 1025 (1983).

Serious Mental Illness -- Source of Findings -- Montana State Hospital as Least Restrictive: The District Court found that C.M. was seriously mentally ill and committed her to Warm Springs State Hospital (now Montana State Hospital). C.M. appealed from the order of commitment. Three persons testified at the commitment hearing, C.M., C.M.'s mother, and a psychiatrist. The psychiatrist testified that C.M. was seriously mentally ill (see 1997 amendment) based on his own examination and on the observations of C.M.'s mother. The court held that a professional person may opine that a person is seriously mentally ill (see 1997 amendment) even though the evidence of an imminent threat of injury, required by statute, is obtained from a source other than the professional person. There was also sufficient evidence that a commitment to Warm Springs State Hospital (now Montana State Hospital) was the least restrictive form of commitment. The order of the District Court was affirmed. In re C.M., 195 M 171, 635 P2d 273, 38 St. Rep. 1768 (1981).

Requirements to Support Finding of Serious Mental Illness: Appellant appeals from a commitment order based on a finding that he is seriously mentally ill (see 1997 amendment). Such a finding requires the state to show (1) a mental disorder; and (2) that the mental disorder has resulted in self-inflicted injury, injury to others, or an "imminent threat thereof". In light of the difficulty of predicting that a given mental state is likely to result in future antisocial conduct, it is necessary to require the commission of some overt act. When this is coupled with psychiatric evaluation, the court will then be in a better position to assess the likelihood of the individual committing similar acts. The law requires only proof beyond a reasonable doubt that the threat of future injury presently exists and that the threat is imminent, that is, impending, likely to occur at any moment. The record showed that appellant caused several disturbances at the hotel where he stayed and then at the hospital. The record supported the finding that the appellant posed an "imminent threat of injury to others" and met the definition of "seriously mentally ill" in the statute (see 1997 amendment). In re F.B., 189 M 229, 615 P2d 867, 37 St. Rep. 1442 (1980). See also Reiser v. Prunty, 224 M 1, 727 P2d 538, 43 St. Rep. 1967 (1986).

Reversal of Conviction as Creating Emergency Situation: The Supreme Court reversed a deliberate homicide conviction and ordered a new trial. The court noted that if the State decides that further prosecution is not possible, then an "emergency situation" would exist under 53-21-129 and in such event ordered the State to detain the defendant and to conduct an emergency evaluation. St. v. Allies, 186 M 99, 606 P2d 1043 (1979).

Determination of Mental Illness -- Overt Act: A person who has spent a substantial portion of the last 20 years in institutions and who has a history of threatening others was found to be "seriously mentally ill", as defined by statute (see 1997 amendment). The statute requires an overt act and,
while every threat cannot be considered an overt act, the testimony and circumstances of this case indicated that the appellant's threat fulfilled the requirement. In re Goedert, 180 M 484, 591 P2d 222, 36 St. Rep. 393 (1979).

Psychologist/Patient Privilege -- Exception: The court properly permitted testimony of respondent's institutional psychologist and psychiatrist, in spite of the psychologist/patient and physician/patient privileges because mental health professionals on the hospital staff qualify as "neutral factfinders". In re Sonsteng, 175 M 307, 573 P2d 1149 (1977); In re Miller, 175 M 318, 573 P2d 1155 (1977).

Collateral References

56 C.J.S. Mental Health §§ 2, 4.

MCA 53-21-102, MT ST 53-21-102

Current through the 2005 Regular Session of the 59th Legislature

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Records and papers in proceedings under this part shall be maintained separately by the clerks of the several courts. Five days prior to the release of a respondent or patient committed to a mental health facility, the facility shall notify the clerk of the court, and the clerk shall immediately seal the record in the case and omit the name of the respondent or patient from the index or indexes of cases in the court unless the court orders the record opened for good cause shown.

History: En. 38-1309 by Sec. 9, Ch. 466, L. 1975; amd. Sec. 9, Ch. 546, L. 1977; R.C.M. 1947, 38-1309(5); amd. Sec. 2, Ch. 547, L. 1979.
53-21-107. Abuse and neglect of persons admitted to mental health facility prohibited -- reporting -- investigations

(1) Any form of abuse or neglect of a person admitted to a mental health facility is prohibited.

(2) Each mental health facility shall publish policies and procedures that define the facility’s guidelines for detecting, reporting, investigating, determining the validity, and resolving allegations of abuse or neglect.

(3) Each allegation of abuse or neglect must be reported as follows:

(a) Any employee of the mental health facility with knowledge of the allegation shall immediately report the allegation to the professional person in charge of the facility.

(b) The professional person in charge of the mental health facility shall report the allegation by the end of the next business day, in writing, to the board.

(c) When the allegation of abuse or neglect may constitute a criminal act, the professional person in charge of the mental health facility shall immediately report the allegation to the appropriate law enforcement authority.

(4) Each mental health facility shall provide a mechanism for reporting allegations of abuse or neglect that in no way deters or discourages an individual from reporting the allegations.

(5) Investigations of allegations of abuse or neglect must be initiated by the professional person in charge of the facility as soon as possible after the initial report of the incident, but not later than by the end of the next business day. Initiation of each investigation may not be delayed in any way that adversely affects the efficacy of the investigation. However, the investigation must be initiated immediately when there is a report of an alleged criminal act.

(6) The investigation of each allegation of abuse or neglect must be concluded within the minimum period of time necessary to gather the information relative to each allegation and to come to a conclusion following the initial report of the allegation.

(7) Each mental health facility shall document the following in writing regarding each allegation of abuse or neglect:

(a) details of each allegation of abuse or neglect, including the names of any facility staff against whom the allegation is made;

(b) a description of the rationale for conducting the investigation with either in-house or outside personnel;

(c) details of the process of the investigation of each allegation of abuse or neglect;

(d) details of the conclusions of the investigation; and

(e) details of corrective action taken.

(8) Mental health facilities shall provide a copy of the written report described in subsections (7)(a) through (7)(e) within 5 working days of the completion of each investigation to the director of the department and to the board.

History: En. Sec. 4, Ch. 344, L. 2001.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

Effective Date: This section is effective October 1, 2001.

MCA 53-21-107, MT ST 53-21-107

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT

§ 53-21-111. Voluntary admission -- content of admission form -- requirements for valid admission

(1) (a) This part may not be construed to limit the right of a person to make voluntary application for admission at any time to a mental health facility or professional person.

(b) An application for admission to a mental health facility must be in writing on a form prescribed by the facility. The form must explain:

(i) the process for requesting release and that the request must be in writing;

(ii) that the individual applying for release may be held involuntarily for up to 5 days after requesting release; and

(iii) that the facility may request a court to involuntarily commit the applicant.

(c) A statement of the rights of the person voluntarily applying for admission, as set out in this part, must be furnished to the patient within 12 hours.

(2) An applicant who wishes to voluntarily apply for admission to the state hospital shall first obtain certification from a professional person that the applicant is suffering from a mental disorder. The professional person shall then obtain confirmation from the department or the department's designee that the facilities available to the mental health region in which the applicant resides are unable to provide adequate evaluation and treatment. The department shall adopt rules to establish a procedure whereby a professional person shall obtain the confirmation from the department or the department's designee as required in this section.

(3) An application for voluntary admission must give the facility the right to detain the applicant for no more than 5 days, excluding weekends and holidays, past the applicant's written request for release. A mental health facility may adopt rules providing for detention of the applicant for less than 5 days. The facility shall notify all applicants of the rules and post the rules as provided in 53-21-168.

(4) An individual applying for voluntary admission pursuant to this section may not be admitted unless:

(a) the admission is approved by a professional person;

(b) the individual applying for admission has been informed orally of the matters required by subsection (1)(b) to be stated in the written application for admission;

(c) a copy of the written application for admission has been given to the applicant; and

(d) the admission otherwise complies with the requirements of this section.

(5) A person voluntarily entering or remaining in a mental health facility shall enjoy all the rights secured to a person involuntarily committed to the facility.

History: En. 38-1303 by Sec. 3, Ch. 466, L. 1975; amd. Sec. 3, Ch. 546, L. 1977; R.C.M. 1947, 38-1303(1) thru (3), (6); amd. Sec. 3, Ch. 547, L. 1979; amd. Sec. 1, Ch. 603, L. 1985; amd. Sec. 10, Ch. 590, L. 1995; amd. Sec. 1, Ch. 247, L. 1999.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

1999 Amendment: Chapter 247 at end of first sentence in (1)(b) after "facility" deleted "and approved by the department" and deleted former second sentence that read: "An application is not valid unless it is approved by a professional person and a copy is given to the person being voluntarily admitted"; inserted (1)(b)(i) through (1)(b)(iii) outlining explanations form must include; in (1)(c) near middle after "this part" deleted "including the right to release"; inserted (4) outlining requirements for valid voluntary admission; and made minor changes in style. Amendment effective April 5, 1999.

1995 Amendment: Chapter 590 in (2), in second and third sentences after "from", substituted "the
department or the department's designee" for "a community mental health center"; and made minor changes in style.

1985 Amendment: In (2), at beginning of second sentence inserted "The professional person must then obtain confirmation from a community mental health center", and at end of second sentence, after "treatment", deleted "except such certification is not necessary if the applicant obtains certification from the regional mental health director of his mental health region that the applicant is financially unable to receive evaluation and treatment from the facilities available to the mental health region", and inserted last sentence of (2) requiring establishment of a confirmation procedure.

Statement of Intent: The statement of intent attached to Ch. 603, L. 1985, provided: "A statement of intent is required for this bill because it contains a delegation of authority, as defined in 5-4-403 [now repealed], providing the department of institutions [now department of corrections] statutory authorization to adopt rules to implement the provisions of the bill requiring confirmation that adequate treatment and evaluation are unavailable in the community.

The legislature contemplates that the department's rules will define the confirmation process in such a way as to provide adequate screening of voluntary admissions to the state hospital without creating an undue delay in meeting the needs of patients.

Specifically, the department should adopt rules that will address:

(1) adoption of a procedure requiring a written statement signed by an authorized person from the community mental health center either before or at the time the confirmation is obtained;

(2) the qualifications of community mental health staff who may confirm voluntary admissions;

(3) the procedure to be used in receiving confirmation from a community mental health center;

(4) the information about the patient and his treatment needs that must be communicated to the community mental health center by the professional person seeking confirmation;

(5) the method used by the mental health center to document the confirmation provided; and

(6) any other reasonable consideration not inconsistent with the purpose of this bill."

Administrative Rules

Title 37, chapter 66, subchapter 3, ARM Voluntary admissions to Montana State Hospital.

Attorney General's Opinions

Involuntary Commitment:

A person subject to court jurisdiction under a petition for involuntary mental commitment may not avoid the involuntary procedure solely by making an application for voluntary admission. 37 A.G. Op. 106 (1978).

County Financial Responsibility for Indigents:

A county is financially responsible for a voluntary commitment proceeding of an indigent person. 36 A.G. Op. 98 (1976).
Notwithstanding any other provision of law, a parent or guardian of a minor may consent to mental health services to be rendered to the minor by:

(a) a facility;

(b) a person licensed in this state to practice medicine; or

(c) a mental health professional licensed in this state.

(2) A minor who is at least 16 years of age may, without the consent of a parent or guardian, consent to receive mental health services from those facilities or persons listed in subsection (1).

(3) Except as provided by this section, the provisions of 53-21-111 apply to the voluntary admission of a minor to a mental health facility but not to the state hospital.

(4) Except as provided by this subsection, voluntary admission of a minor to a mental health facility for an inpatient course of treatment is for the same period of time as that for an adult. A minor voluntarily admitted with consent of the minor's parent or guardian has the right to be released within 5 days of a request by the parent or guardian as provided in 53-21-111(3). A minor who has been admitted without consent by a parent or guardian, pursuant to subsection (2), may also make a request and also has the right to be released within 5 days as provided in 53-21-111(3). Unless there has been a periodic review and a voluntary readmission consented to by the parent or guardian in the case of a minor patient or consented to by the minor alone in the case of a minor patient who is at least 16 years of age, voluntary admission terminates at the expiration of 1 year. Counsel must be appointed for the minor at the minor's request or at any time that the minor is faced with potential legal proceedings.
MONTANA CODE ANNOTATED
TITLE 53. SOCIAL SERVICES AND INSTITUTIONS
CHAPTER 21. MENTALLY ILL
PART 1. TREATMENT OF THE SERIOUSLY MENTALLY ILL

53-21-114. Notice of rights to be given

(1) Whenever a person is involuntarily detained pursuant to 53-21-121 through 53-21-126, the person shall at the time of detention be informed of his constitutional rights and his rights under this part. Within 3 days of such detention, he must also be informed in writing by the county attorney of such rights.

(2) Every respondent subject to an order for short-term treatment or long-term care and treatment shall be advised in writing of his right to appeal the order by the court at the conclusion of any hearing the result of which such an order may be entered.

History: (1)En. 38-1304 by Sec. 4, Ch. 466, L. 1975; amd. Sec. 4, Ch. 546, L. 1977; Sec. 38-1304, R.C.M. 1947; (2)En. 38-1309 by Sec. 9, Ch. 466, L. 1975; amd. Sec. 9, Ch. 546, L. 1977; Sec. 38-1304, R.C.M. 1947; R.C.M. 1947, 38-1304(part), 38-1309(4); amd. Sec. 1, Ch. 522, L. 1983; amd. Sec. 1, Ch. 537, L. 1991.

Case Notes

1991 Amendment: In (1), in three places after reference to detention, deleted reference to examination.

1983 Amendment: In (1), after "shall", inserted "at the time of detention or examination"; inserted last sentence of (1) requiring that an involuntarily detained person be informed in writing of his rights within 3 days of detention; and in (2), after "advised", inserted "in writing".

Cross-References

Due process of law, Art. II, sec. 17, Mont. Const.

Attorney General's Opinions

Duty of Mental Health Professional to Inform Involuntarily Committed Patient of Rights:

A certified professional person has knowledge of a detainee's rights and the law requiring notice of those rights. Therefore, a mental health professional examining a person under a petition for involuntary commitment must determine whether the person has been informed of his rights and, if not, inform him of those rights. 43 A.G. Op. 64 (1990).

Collateral References

53 Am. Jur. 2d Mentally Impaired Persons § § 24, 35.
MONTANA CODE ANNOTATED
TITLE 53. SOCIAL SERVICES AND INSTITUTIONS
CHAPTER 21. MENTALLY ILL
PART 1. TREATMENT OF THE SERIOUSLY MENTALLY ILL

53-21-115. Procedural rights

In addition to any other rights that may be guaranteed by the constitution of the United States and of this state, by the laws of this state, or by this part, any person who is involuntarily detained or against whom a petition is filed pursuant to this part has the following rights:

(1) the right to notice reasonably in advance of any hearing or other court proceeding concerning the person;

(2) the right in any hearing to be present, to offer evidence, and to present witnesses in any proceeding concerning the person;

(3) the right to know, before a hearing, the names and addresses of any witnesses who will testify in support of a petition;

(4) the right in any hearing to cross-examine witnesses;

(5) the right to be represented by counsel;

(6) the right to remain silent;

(7) the right in any hearing to be proceeded against according to the rules of evidence applicable to civil matters generally;

(8) the right to view and copy all petitions on file with the court concerning the person;

(9) the right to be examined by a professional person of the person's choice when the professional person is willing and reasonably available;

(10) the right to be dressed in the person's own clothes at any hearing held pursuant to this part;

(11) the right to refuse any but lifesaving medication for up to 24 hours prior to any hearing held pursuant to this part; and

(12) the right to voluntarily take necessary medications prior to any hearing pursuant to this part.

History: En. 38-1304 by Sec. 4, Ch. 466, L. 1975; amd. Sec. 4, Ch. 546, L. 1977; R.C.M. 1947, 38-1304(4); amd. Sec. 5, Ch. 547, L. 1979; amd. Sec. 3, Ch. 376, L. 1987; amd. Sec. 17, Ch. 490, L. 1997.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

1997 Amendment: Chapter 490 inserted (3) regarding the right to know; inserted (12) regarding the right to voluntarily take medications; and made minor changes in style. Amendment effective July 1, 1997.

Saving Clause: Section 40, Ch. 490, L. 1997, was a saving clause.

1987 Amendment: Inserted (2) establishing the right to know the names and addresses of witnesses in advance of hearing.

Cross-References

Due process of law, Art. II, sec. 17, Mont. Const.

Case Notes

Right to Effective Assistance of Counsel for Person Subject to Involuntary Commitment Because of Mental Disorder -- Strickland Test for Ineffective Assistance Inappropriate in Involuntary Commitment Proceedings: The right to counsel afforded by state law regarding the treatment of the seriously mentally ill provides a person who is subject to an involuntary commitment proceeding the right to effective assistance of counsel, which in turn provides that person the right to raise the allegation of ineffective assistance of counsel when challenging a commitment order. The test for ineffective assistance of counsel set out in Strickland v. Wash., 466 US 668 (1984), is inappropriate in involuntary commitment proceedings. However, the Strickland test simply does not go far enough to protect the liberty interests of persons involved in involuntary commitment proceedings who may or may not have broken any
Medical Rights Not Absolute -- Restrictions Proper When Based on Necessity for Treatment, Evaluation, and Care: G.J.P. claimed numerous violations of his procedural and constitutional rights regarding the provision of his medical care after being confined for his manic episodes, including claims that: (1) a medical professional lacked knowledge of the requisite facts to make a request for commitment; (2) a mental evaluation was improperly conducted; (3) he was improperly secluded in isolation and restrained; (4) he was denied medical care for broken ribs; (5) he was denied the right of telephone communications; and (6) he was administered medication within 24 hours before his initial hearing on a motion for commitment, despite his objections. The Supreme Court recognized the rights of patients to receive proper medical care but noted that none of the rights are absolute. G.J.P. did not demonstrate any restrictions on his rights other than those necessary for his treatment, evaluation, and care or establish that reversal of his commitment would be a proper remedy for a denial or restriction of his rights. In re G.J.P., 266 M 370, 880 P2d 1311, 51 St. Rep. 847 (1994).

Lawful Detention Not Violative of Right to Vote: The constitutional right to vote may not be considered to be denied under this section when an emergency detention is lawfully justified. Reiser v. Prunty, 224 M 1, 727 P2d 538, 43 St. Rep. 1967 (1986).

Patient Not Informed of Right to Refuse Medication -- Waiver: A patient argued that the District Court erred in not finding a physician and hospital in violation of 53-21-114 and this section because she was not notified of her right to refuse medication. The Supreme Court held that under 53-21-119 she waived her right to refuse medication by requesting it or at least by not objecting to it and that failure to notify her of her right to refuse did not result in any actionable injury to her. Reiser v. Prunty, 224 M 1, 727 P2d 538, 43 St. Rep. 1967 (1986).

Commitment of Ward -- Due Process Rights -- Notice, Hearing, and Counsel: District Court order committing ward to Montana State Hospital for a 72-hour evaluation upon a request made by the ward's guardian was reversed where ward was not given notice of the impending commitment, an attorney, or a hearing prior to the commitment. The ward's statutory and constitutional due process rights were violated. Two days after the first order the County Attorney, at guardian's request, filed a petition for a 90-day commitment. The guardian consented and waived ward's rights to notice, counsel, and hearing prior to commitment. The petition was granted, which also violated ward's statutory and constitutional rights to due process. He had the right to notice, hearing, and counsel, and only the person to be committed, or if he is unable, his attorney and guardian acting in concert, may waive those rights. The ward had no attorney at the time of the guardian's waiver. In re Simons, 215 M 463, 698 P2d 850, 42 St. Rep. 544 (1985).

Attorney General's Opinions

Commitment Procedures to Be Followed in Committing Mentally Ill Youth -- Private Mental Health Facilities Not Precluded:

Section 41-5-523 (renumbered 41-5-1512) does not authorize the Youth Court or the Department of Family Services (now Department of Public Health and Human Services) to commit a mentally ill or
seriously mentally ill (see 1997 amendment to 53-21-102) youth to a mental health treatment facility without following the commitment procedures set out in Title 53, ch. 21, part 1. There is, however, no statutory preclusion of commitment of a youth to private mental health facilities. 42 A.G. Op. 59 (1988).

Collateral References

56 C.J.S. Mental Health § 23.

53 Am. Jur. 2d Mentally Impaired Persons §§ 24, 36 through 42, 44 through 47.

Competency to stand trial of criminal defendant diagnosed as "schizophrenic"-- modern state cases. 33 ALR 4th 1062.

Necessity and sufficiency of statements informing one under investigation for involuntary commitment of right to remain silent. 23 ALR 4th 563.

Mental subnormality of accused as affecting voluntariness or admissibility of confession. 8 ALR 4th 16.
MONTANA CODE ANNOTATED
TITLE 53. SOCIAL SERVICES AND INSTITUTIONS
CHAPTER 21. MENTALLY ILL
PART 1. TREATMENT OF THE SERIOUSLY MENTALLY ILL

53-21-119. Waiver of rights

(1) A person may waive his rights, or if the person is not capable of making an intentional and knowing decision, these rights may be waived by his counsel and friend of respondent acting together if a record is made of the reasons for the waiver. The right to counsel may not be waived. The right to treatment provided for in this part may not be waived.

(2) The right of the respondent to be physically present at a hearing may also be waived by his attorney and the friend of respondent with the concurrence of the professional person and the judge upon a finding supported by facts that:

(a) the presence of the respondent at the hearing would be likely to seriously adversely affect his mental condition; and

(b) an alternative location for the hearing in surroundings familiar to the respondent would not prevent such adverse effects on his mental condition.

(3) (a) In the case of a minor, provided that a record is made of the reasons for the waiver, his rights may be waived by the mutual consent of his counsel and parents or guardian or guardian ad litem if there are no parents or guardian.

(b) If there is an apparent conflict of interest between a minor and his parents or guardian, the court shall appoint a guardian ad litem for him.

History: En. 38-1304 by Sec. 4, Ch. 466, L. 1975; amd. Sec. 4, Ch. 546, L. 1977; R.C.M. 1947, 38-1304(part); amd. Secs. 6, 14, Ch. 547, L. 1979.

NOTES, REFERENCES, AND ANNOTATIONS

Case Notes

Right to Effective Assistance of Counsel for Person Subject to Involuntary Commitment Because of Mental Disorder -- Strickland Test for Ineffective Assistance Inappropriate in Involuntary Commitment Proceedings: The right to counsel afforded by state law regarding the treatment of the seriously mentally ill provides a person who is subject to an involuntary commitment proceeding the right to effective assistance of counsel, which in turn provides that person the right to raise the allegation of ineffective assistance of counsel when challenging a commitment order. The test for ineffective assistance of counsel set out in Strickland v. Wash., 466 US 668 (1984), is inappropriate in involuntary commitment proceedings. However, the Strickland test simply does not go far enough to protect the liberty interests of persons involved in involuntary commitment proceedings who may or may not have broken any law but who, upon the expiration of a 90-day commitment, must indefinitely bear the badge of inferiority of a once involuntarily committed person with a proved mental disorder. Instead, upon a substantial showing of evidence to the issuing District Court or to the Supreme Court pursuant to 53-21-131 that counsel did not effectively represent the person's interests, an order of involuntary commitment should be vacated. The due process afforded individuals must serve to protect the fundamental liberty interests of dignity and integrity, and it is not only counsel, "but also courts, that are charged with the duty of safeguarding the due process rights of individuals involved at every stage of the proceedings". The Supreme Court identified five critical areas of representation that generally define the scope of effective counsel in involuntary commitment proceedings: (1) appointment of competent counsel; (2) the initial investigation; (3) the client interview; (4) the right to remain silent; and (5) counsel as an advocate and adversary. The statutory and constitutional standards must be rigorously adhered to in order to ensure the fundamental fairness of civil commitment proceedings, and it is imperative that the constitutional and legislated rights be formally and fairly balanced with the state's ultimate power to protect both the individual and the public from actual or perceived harm. In re K.G.F., 2001 MT 140, 306 M 1, 29 P3d 485 (2001), following Conservatorship of Roulet, 590 P2d 1 (Calif. 1979), and distinguishing In re Carmody, 653 NE 2d 977 (Ill. App. Ct. 1995).

Termination of Parental Rights -- Appointment of Guardian for Incompetent Parent or Waiver of Right to Appear Required: Where mother was under
order of commitment and was confined at Montana State Hospital at time of entry of order terminating her parental rights, the Supreme Court reversed and remanded on ground that she was incompetent and either a guardian ad litem should have been appointed for her under Rule 17(c), M.R.Civ.P. (see Title 25, ch. 20), or a waiver of her right to appear under subsection (2) of this section should have been entered. The fact that she was represented by appointed counsel does not meet the requirements of Rule 17(c). Custody of R.A.D., 231 M 143, 753 P2d 862, 44 St. Rep. 2018 (1987). Opinion withdrawn but issue affirmed in Custody of R.A.D. & J.D., 231 M 143, 753 P2d 862, 45 St. Rep. 496 (1988).

Patient Not Informed of Right to Refuse Medication -- Waiver: A patient argued that the District Court erred in not finding a physician and hospital in violation of 53-21-114 and 53-21-115 because she was not notified of her right to refuse medication. The Supreme Court held that under this section she waived her right to refuse medication by requesting it or at least by not objecting to it and that failure to notify her of her right to refuse did not result in any actionable injury to her. Reiser v. Prunty, 224 M 1, 727 P2d 538, 43 St. Rep. 1967 (1986).

Commitment of Ward -- Due Process Rights -- Notice, Hearing, and Counsel: District Court order committing ward to Montana State Hospital for a 72-hour evaluation upon a request made by the ward's guardian was reversed where ward was not given notice of the impending commitment, an attorney, or a hearing prior to the commitment. The ward's statutory and constitutional due process rights were violated. Two days after the first order the County Attorney, at guardian's request, filed a petition for a 90-day commitment. The guardian consented and waived ward's rights to notice, counsel, and hearing prior to commitment. The petition was granted, which also violated ward's statutory and constitutional rights to due process. He had the right to notice, hearing, and counsel, and only the person to be committed, or if he is unable, his attorney and guardian acting in concert, may waive those rights. The ward had no attorney at the time of the guardian's waiver. In re Simons, 215 M 463, 698 P2d 850, 42 St. Rep. 544 (1985).

Collateral References

53 Am. Jur. 2d Mentally Impaired Persons § §
MONTANA CODE ANNOTATED
TITLE 53. SOCIAL SERVICES AND INSTITUTIONS
CHAPTER 21. MENTALLY ILL
PART 1. TREATMENT OF THE SERIOUSLY MENTALLY ILL

53-21-120. Detention to be in least restrictive environment -- preference for mental health facility -- court relief -- prehearing detention of mentally ill person prohibited

(1) A person detained pursuant to this part must be detained in the least restrictive environment required to protect the life and physical safety of the person detained or members of the public; in this respect, prevention of significant injury to property may be considered.

(2) Whenever possible, a person detained pursuant to this part must be detained in a mental health facility and in the county of residence. If the person detained demands a jury trial and the trial cannot be held within 7 days, subject to the provisions in 53-21-193, the individual may be sent to the state hospital or a behavioral health inpatient facility until the time of trial if arrangements can be made to return the person to trial. The trial must be held within 30 days. The county of residence shall pay the cost of travel and professional services associated with the trial. A person may not be detained in any hospital or other medical facility unless the hospital or facility has agreed in writing to admit the person.

(3) A person may not be detained pursuant to this part in a jail or other correctional facility.

(4) A person detained prior to involuntary commitment may apply to the court for immediate relief with respect to the need for detention or the adequacy of the facility being utilized to detain.

History: En. 38-1304 by Sec. 4, Ch. 466, L. 1975; amd. Sec. 4, Ch. 546, L. 1977; R.C.M. 1947, 38-1304(5); amd. Sec. 7, Ch. 547, L. 1979; amd. Sec. 5, Ch. 376, L. 1987; amd. Sec. 1, Ch. 360, L. 1989; amd. Sec. 1, Ch. 636, L. 1991; amd. Sec. 4, Ch. 513, L. 2003.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

2003 Amendment: Chapter 513 in (2) in middle of second sentence inserted "subject to the provisions in 53-21-193" and after "hospital" inserted "or a behavioral health inpatient facility"; and made minor changes in style. Amendment effective July 1, 2003.

Severability: Section 10, Ch. 513, L. 2003, was a severability clause.

1991 Amendment: At beginning of (3) deleted "Except as provided in 53-21-124"; and made minor changes in style. Amendment effective July 1, 1993.

1989 Amendment: In (3) substituted language prohibiting person from being detained in jail or other correctional facility except as provided in 53-21-124 for language stating circumstances under which person may be detained (see 1987 MCA for former text).

1987 Amendment: Inserted (5) disallowing a detention order when a petition has been filed under 53-21-121(1)(b); and inserted (6) disallowing involuntary commitment or detention of certain persons absent serious mental illness.

Case Notes

No Error in Instruction Quoting Statute Verbatim: Joshua Lloyd suffered a seizure after being transferred to the Kalispell Regional Hospital's security room. His personal representative sued the hospital and others. During trial, the District Court instructed the jury on negligence per se by quoting mental health statutes verbatim to the jury. The Supreme Court said that giving jury instructions by quoting directly from the statutes may not be the best practice, but noted that the instructions proposed by opposing counsel were also direct quotations of mental health statutes. Given that situation, the Supreme Court held that there was no error in giving jury instructions in the form of direct quotations from the statutes. Buhr v. Flathead County, 268 M. 223, 886 P2d 381, 51 St. Rep. 1258 (1994).

Hospital's Failure to Agree in Writing to Detainment -- No Negligence: The provisions of this
section that no person may be detained unless the hospital or mental health facility agrees in writing to admission does not create a basis of liability but is intended to aid in proof that the patient was in fact admitted. When the hospital did not deny admitting the patient, a prima facie case of negligence could not be made. Reiser v. Prunty, 224 M 1, 727 P2d 538, 43 St. Rep. 1967 (1986).

Weight Given Professional Decision as to Least Restrictive Environment: By its very nature, the concept of a least restrictive environment involves medical connotations outside the scope of knowledge of the layperson and is a judgment that can only be made by an expert who has considered all facts of the case in light of what would be reasonable in similar circumstances. Absent evidence that a patient was placed in other than the least restrictive environment, her lay observations were insufficient to defeat District Court award of summary judgment to the attending physician and the hospital. Reiser v. Prunty, 224 M 1, 727 P2d 538, 43 St. Rep. 1967 (1986).

Stipulation to Commitment -- Montana State Hospital as Least Restrictive Environment: The appellant, M.C., argued on appeal that evidence was insufficient to warrant his transfer to Montana State Hospital. At a commitment hearing, the District Court heard evidence on M.C.’s inability to cooperate in treatment at the Billings Mental Health Center, as well as testimony from a Center doctor indicating that Montana State Hospital was the least restrictive environment in which M.C. could receive the care and supervision he needed. After the hearing, M.C. and his counsel stipulated to, and the District Court ordered, a commitment to the Billings Mental Health Center or "another mental health facility in Montana". The Supreme Court held this evidence to be sufficient to support the District Court's action in committing M.C. to the Montana State Hospital. In re M.C., 220 M 437, 716 P2d 203, 43 St. Rep. 508 (1986).

Serious Mental Illness -- Source of Findings -- Montana State Hospital as Least Restrictive: The District Court found that C.M. was seriously mentally ill (see 1997 amendment to 53-21-102) and committed her to Warm Springs State Hospital (now Montana State Hospital). C.M. appealed from the order of commitment. Three persons testified at the commitment hearing, C.M., C.M.’s mother, and a psychiatrist. The psychiatrist testified that C.M. was seriously mentally ill based on his own examination and on the observations of C.M.’s mother. The court held that a professional person may opine that a person is seriously mentally ill (see 1997 amendment to 53-21-102) even though the evidence of an imminent threat of injury, required by statute, is obtained from a source other than the professional person. There was also sufficient evidence that a commitment to Warm Springs State Hospital (now Montana State Hospital) was the least restrictive form of commitment. The order of the District Court was affirmed. In re C.M., 195 M 171, 635 P2d 273, 38 St. Rep. 1768 (1981).

MCA 53-21-120, MT ST 53-21-120

Current through the 2005 Regular Session of the 59th Legislature
53-21-129. Emergency situation -- petition -- detention

(1) When an emergency situation exists, a peace officer may take any person who appears to have a mental disorder and to present an imminent danger of death or bodily harm to the person or to others into custody only for sufficient time to contact a professional person for emergency evaluation. If possible, a professional person should be called prior to taking the person into custody.

(2) If the professional person agrees that the person detained is a danger to the person or to others because of a mental disorder and that an emergency situation exists, then the person may be detained and treated until the next regular business day. At that time, the professional person shall release the detained person or file findings with the county attorney who, if the county attorney determines probable cause to exist, shall file the petition provided for in 53-21-121 through 53-21-126 in the county of the respondent's residence. In either case, the professional person shall file a report with the court explaining the professional person's actions.

(3) The county attorney of a county may make arrangements with a federal, state, regional, or private mental facility or with a mental health facility in a county for the detention of persons held pursuant to this section. If an arrangement has been made with a facility that does not, at the time of the emergency, have a bed available to detain the person at that facility, the person may be transported to the state hospital or to a behavioral health inpatient facility, subject to 53-21-193 and subsection (4) of this section, for detention and treatment as provided in this part. This determination must be made on an individual basis in each case, and the professional person at the local facility shall certify to the county attorney that the facility does not have adequate room at that time.

(4) Before a person may be transferred to the state hospital or to a behavioral health inpatient facility under this section, the state hospital or the behavioral health inpatient facility must be notified prior to transfer and shall state whether a bed is available for the person. If the Montana state hospital determines that a behavioral health inpatient facility is the appropriate facility for the emergency detention, it shall direct the person to the appropriate facility to which the person must be transported for emergency detention.

History: En. 38-1307 by Sec. 7, Ch. 466, L. 1975; amd. Sec. 7, Ch. 546, L. 1977; R.C.M. 1947, 38-1307; amd. Sec. 1, Ch. 560, L. 1983; amd. Sec. 25, Ch. 490, L. 1997; amd. Sec. 7, Ch. 513, L. 2003.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

2003 Amendment: Chapter 513 in (3) in second sentence after "hospital" inserted "or to a behavioral health inpatient facility, subject to 53-21-193 and subsection (4) of this section"; in (4) in two places in first sentence after "hospital" inserted references to a behavioral health inpatient facility and inserted second sentence requiring Montana state hospital to direct person to appropriate facility for emergency detention upon determination that behavioral health inpatient facility is appropriate facility; and made minor changes in style. Amendment effective July 1, 2003.

Severability: Section 10, Ch. 513, L. 2003, was a severability clause.

1997 Amendment: Chapter 490 in (1), after "appears to", substituted "have a mental disorder and to present an imminent danger of death or bodily harm to the person or to others" for "be seriously mentally ill and as a result of serious mental illness to be a danger to others or to himself"; in (2), in first sentence after "detained", substituted "is a danger to the person or to others because of a mental disorder" for "appears to be seriously mentally ill"; and made minor changes in style. Amendment effective July 1, 1997.

Saving Clause: Section 40, Ch. 490, L. 1997, was a saving clause.

1983 Amendment: After first sentence of (3) inserted remainder of (3) providing for emergency detention at the state hospital upon proper certification; and inserted (4) requiring that the state
hospital be notified and state that a bed is available.

Case Notes

*No Error in Instruction Quoting Statute Verbatim:* Joshua Lloyd suffered a seizure after being transferred to the Kalispell Regional Hospital's security room. His personal representative sued the hospital and others. During trial, the District Court instructed the jury on negligence per se by quoting mental health statutes verbatim to the jury. The Supreme Court held that giving jury instructions by quoting directly from the statutes may not be the best practice, but noted that the instructions proposed by opposing counsel were also direct quotations of mental health statutes. Given that situation, the Supreme Court held that there was no error in giving jury instructions in the form of direct quotations from the statutes. *Buhr v. Flathead County*, 268 M 223, 886 P2d 381, 51 St. Rep. 1258 (1994).

*No Negligence Per Se by Mental Health Cooperative Evaluation at Variance With Statute -- Jury Verdict Supported by Substantial Evidence:* Joshua died after suffering a seizure while in the custody of the Sheriff in a soft cell. Buhr, his personal representative, sued the county, the Sheriff, and others. Testimony at trial showed that despite the implication in subsection (2) of this section that Joshua be examined by a professional person, he was instead examined by Russell, who was not a professional person. Testimony showed that Russell then consulted with Harris, who was a professional person. Based upon the consultation, Harris agreed that Joshua needed to be placed in an emergency mental health hold status. The Supreme Court noted that although conflicting evidence may have been presented as to whether this procedure violated the statute, the evidence was presented to the jury based upon an appropriate instruction to which there was no objection. The Supreme Court held that the jury's verdict finding no negligence was supported by substantial evidence. *Buhr v. Flathead County*, 268 M 223, 886 P2d 381, 51 St. Rep. 1258 (1994).

*Medical Rights Not Absolute -- Restrictions Proper When Based on Necessity for Treatment, Evaluation, and Care:* G.J.P. claimed numerous violations of his procedural and constitutional rights regarding the provision of his medical care after being confined for his manic episodes, including claims that: (1) a medical professional lacked knowledge of the requisite facts to make a request for commitment; (2) a mental evaluation was improperly conducted; (3) he was improperly secluded in isolation and restrained; (4) he was denied medical care for broken ribs; (5) he was denied the right of telephone communications; and (6) he was administered medication within 24 hours before his initial hearing on a motion for commitment, despite his objections. The Supreme Court recognized the rights of patients to receive proper medical care but noted that none of the rights are absolute. G.J.P. did not demonstrate any restrictions on his rights other than those necessary for his treatment, evaluation, and care or establish that reversal of his commitment would be a proper remedy for a denial or restriction of his rights. *In re G.J.P.*, 266 M 370, 880 P2d 1311, 51 St. Rep. 847 (1994).

*Probable Cause Found for Taking Into Custody -- Peace Officers Immune From Liability:* Maag had suffered for several weeks from the effects of mixing toxic chemicals, including poor logic, slurred speech, and lack of coordination. At the request of his family, relatives, and friends, he was taken into custody by peace officers and brought to a hospital for observation at the request of a physician. After his release by the hospital the following day, Maag sued the peace officers in federal court, claiming violation of his fourth amendment rights. Defendants' motion for summary judgment was denied by the District Court. The court of appeals held that the standard for deciding whether Maag's constitutional rights had been violated was whether there was probable cause for the defendants to take him into custody. The court held that the officers had clear authority under this section and under the facts, including both the requests to arrest Maag and the officers' own observations of his conduct. The court found the defendants immune and awarded them attorney fees. *Maag v. Wessler*, 944 F2d 654 (9th Cir. 1991).
Adequate Medical Care Not Basis for Disregarding Due Process: The medical center, in which the respondent was placed by the officers who picked her up, did not follow proper procedure, and the respondent was held without authority for 5 days before her competency hearing. The Supreme Court held that providing adequate medical care is not a basis for disregarding the due process and statutory rights of a person charged with being seriously mentally ill (see 1997 amendment). The court went on to admonish the medical center, the County Attorney's office, and the county family services department for their failure to comply with the due process rights of the respondent. Mental Health of E.P., 241 M 316, 787 P2d 322, 47 St. Rep. 297 (1990).

Statutory Requirements Not Adhered to by Medical Center: A woman was brought by police to the medical center because the officers believed that she was seriously mentally ill (see 1997 amendment). Although the center extended good medical coverage, it held the woman for 5 days rather than 1 before petitioning the District Court to commit her. The lower court found that the evidence demonstrated that the respondent was totally unable to take care of herself. The Supreme Court stated that after reviewing the record, it found that there was overwhelming evidence to support the lower court's finding. The Supreme Court stated that although the case was moot in that the woman had been subsequently released, the medical center had not met the statutory guidelines. The court cautioned that proper procedures should be established to protect the due process rights of the mentally ill. Mental Health of E.P., 241 M 316, 787 P2d 322, 47 St. Rep. 297 (1990).

Suicidal Threats Constituting Emergency Situation: Threats to kill oneself as well as others, angry and abusive conduct toward others, a state of depression lasting a period of a week, and evidence of a previous suicide attempt 2 months earlier clearly indicated an emergency situation warranting detention under this section. Reiser v. Prunty, 224 M 1, 727 P2d 538, 43 St. Rep. 1967 (1986).

Detention Prior to Court Finding of Serious Mental Illness -- Determination by Professional Person Rather Than Peace Officer: Appellant, M.C., argued that under 53-21-129, the peace officer makes the initial decision on whether an emergency situation exists and that in this case the officer did not make that decision. M.C. also contended that the evidence was insufficient to hold him on an emergency basis. The Supreme Court held that 53-21-129 merely permits the officer to take a person into custody for an evaluation. It does not give the officer authority to decide whether the person should be placed in emergency detention; rather, the professional person determines whether the person is seriously mentally ill (see 1997 amendment) and should be placed in emergency detention. Once that determination is made, it constitutes sufficient evidence that the person may be detained. In re M.C., 220 M 437, 716 P2d 203, 43 St. Rep. 508 (1986).

Commitment Procedural Safeguards Ignored: The State failed to follow the commitment procedural safeguards in handling Shennum's commitment. The record does not evidence the existence of an emergency situation sufficient to invoke 53-21-129. Shennum was not advised of his constitutional rights before a medical examination incorrectly obtained under a purported emergency situation. Absent an emergency, it was the duty of the County Attorney to proceed in accordance with 53-21-121 through 53-21-126 in order to commit Shennum as a seriously mentally ill person. Several of the procedural protections contained in those sections were ignored. Therefore, the initial commitment was reversed with guidelines for the State to proceed properly in further commitment proceedings. In re Shennum, 210 M 442, 684 P2d 1073, 41 St. Rep. 1148 (1984), distinguished in In re G.J.P., 266 M 370, 880 P2d 1311, 51 St. Rep. 847 (1994), because G.J.P. was detained at the request of a professional person and because at the time of appeal, G.J.P. was no longer detained as the result of the court proceeding.

Reversal of Conviction as Creating Emergency Situation: The Supreme Court reversed a deliberate homicide conviction and ordered a new trial. The court noted that if the State decides that further prosecution is not possible, then an "emergency situation" would exist under 53-21-129 and in such event ordered the State to detain the defendant and to conduct an emergency evaluation. St. v. Allies, 186 M 99, 606 P2d 1043 (1979).

Attorney General's Opinions

County Liability for Costs of Precommitment Services:

Subject to the limitations in 53-21-132(2), the county of residence is financially responsible for costs incurred in connection with the detention and
precommitment custody of persons taken into protective custody pursuant to 53- 21-124 or this section. 46 A.G. Op. 18 (1996).

**Detainment in Emergency Situation During Business Hours:**

Nothing in this section indicates that a person may not be detained during business hours. In an emergency situation, a person may be detained at any time and treated until the next regular business day, at which time he must be released or proceedings must be initiated pursuant to 53-21-121. 43 A.G. Op. 5 (1989).
(1) An individual 18 years of age or older with mental capacity may voluntarily execute a mental health advance directive providing that if the individual is treated for a mental disorder at an inpatient facility, the directions concerning who must be notified and who may visit the individual, as provided in this section, are to be followed. An inpatient facility that is furnished a copy of a mental health advance directive shall comply with the directive and shall make the directive a part of the individual's medical record.

(2) The directive may address any combination of the following subjects:

(a) who should be notified promptly in the event of the individual's admission to or treatment at the facility;

(b) who should or should not be allowed to visit the individual at the facility; and

(c) the duration of the directive.

(3) The directive authorized in subsection (1) must be in writing and must contain:

(a) a statement that the individual has the mental capacity to execute the directive and that the directive is executed voluntarily;

(b) a statement that once signed, a directive of which the facility is furnished a copy takes effect upon the determination of the lack of mental capacity by the treating mental health professional of the individual and remains in effect until:

(i) revoked by the individual, orally or in writing, at a time that the individual has the mental capacity to revoke the advance directive, as determined by the treating mental health professional;

(ii) the directive expires by its own terms; or

(iii) the individual dies;

(c) the signature of the individual; and

(d) the signature of two witnesses.

(4) (a) An individual may revoke a mental health advance directive provided that the mental health professional chosen by or provided for the individual determines in good faith that the individual has sufficient mental capacity to revoke the directive. The inpatient facility shall make a valid revocation a part of the individual's medical record.

(b) An advance directive is valid and enforceable only with respect to the matters provided for in subsection (2) even if the directive addresses subjects in addition to those provided for in this section.

(5) If an inpatient facility fails to act in accordance with a mental health advance directive of which the facility was furnished a copy, an individual who has executed the mental health advance directive or who has the right to be notified or to visit the individual at the facility pursuant to a mental health advance directive has a cause of action against the facility for injunctive relief and reasonable costs and attorney fees incurred in bringing the action.

(6) As used in this section, the following definitions apply:

(a) "Advance directive" or "directive" means a writing complying with the requirements of this section.

(b) "Inpatient facility" or "facility" means a health care facility that provides emergency, crisis, or acute care to a person with a mental disorder.

(c) (i) "Lack of mental capacity" means that an individual does not have sufficient ability to make or communicate decisions regarding a need for treatment.

(ii) The lack of mental capacity does not require that a person be legally determined to be an incapacitated person, as defined in 72-5-101. However, a person who is under a current legal determination of being an incapacitated person has a lack of mental capacity.

(d) "Mental capacity" means sufficient ability to
MCA 53-21-153, MT ST 53-21-153

make or communicate decisions regarding a need for treatment.

History: En. Sec. 1, Ch. 533, L. 2001.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

Effective Date: This section is effective October 1, 2001.

Applicability: Section 3, Ch. 533, L. 2001, provided: "[This act] applies to an advance directive, as defined in [section 1] [53-21-153], signed on or after October 1, 2001."

MCA 53-21-153, MT ST 53-21-153

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
MONTANA CODE ANNOTATED
TITLE 53. SOCIAL SERVICES AND INSTITUTIONS
CHAPTER 21. MENTALLY ILL
PART 1. TREATMENT OF THE SERIOUSLY MENTALLY ILL

53-21-162. Establishment of patient treatment plan -- patient's rights

(1) Each patient admitted as an inpatient to a mental health facility must have a comprehensive physical and mental examination and review of behavioral status within 48 hours after admission to the mental health facility.

(2) Each patient must have an individualized treatment plan. This plan must be developed by appropriate professional persons, including a psychiatrist, and must be implemented no later than 10 days after the patient's admission. Each individualized treatment plan must contain:

(a) a statement of the nature of the specific problems and specific needs of the patient;

(b) a statement of the least restrictive treatment conditions necessary to achieve the purposes of hospitalization;

(c) a description of treatment goals, with a projected timetable for their attainment;

(d) a statement and rationale for the plan of treatment for achieving these goals;

(e) a specification of staff responsibility for attaining each treatment goal;

(f) criteria for release to less restrictive treatment conditions; and

(g) a notation of any therapeutic tasks and labor to be performed by the patient.

(3) Overall development, implementation, and supervision of the treatment plan must be assigned to an appropriate professional person.

(4) The inpatient mental health facility shall periodically reevaluate the patient and revise the individualized treatment plan based on changes in the patient's condition. At a minimum, the treatment plan must be reviewed:

(a) at the time of any transfer within the facility;

(b) at the time of discharge;

(c) upon any major change in the patient's condition;

(d) at the conclusion of the initial estimated length of stay and subsequent estimated lengths of stay;

(e) no less than every 90 days; and

(f) at each of the times specified in subsections (4)(a) through (4)(e), by a treatment team that includes at least one professional person who is not primarily responsible for the patient's treatment plan.

(5) A patient has the right:

(a) to ongoing participation, in a manner appropriate to the patient's capabilities, in the planning of mental health services to be provided and in the revision of the plan;

(b) to a reasonable explanation of the following, in terms and language appropriate to the patient's condition and ability to understand:

(i) the patient's general mental condition and, if given a physical examination, the patient's physical condition;

(ii) the objectives of treatment;

(iii) the nature and significant possible adverse effects of recommended treatments;

(iv) the reasons why a particular treatment is considered appropriate;

(v) the reasons why access to certain visitors may not be appropriate; and

(vi) any appropriate and available alternative treatments, services, or providers of mental health services; and

(c) not to receive treatment established pursuant to the treatment plan in the absence of the patient's informed, voluntary, and written consent to the treatment, except treatment:
(i) during an emergency situation if the treatment is pursuant to or documented contemporaneously by the written order of a responsible mental health professional; or

(ii) permitted under the applicable law in the case of a person committed to a facility by a court.

(6) In the case of a patient who lacks the capacity to exercise the right to consent to treatment described in subsection (5)(c), the right must be exercised on behalf of the patient by a guardian appointed pursuant to the provisions of Title 72, chapter 5.

(7) The department shall develop procedures for initiating limited guardianship proceedings in the case of a patient who appears to lack the capacity to exercise the right to consent described in subsection (5)(c).

History: En. 38-1324 by Sec. 24, Ch. 466, L. 1975; amd. Sec. 13, Ch. 546, L. 1977; R.C.M. 1947, 38-1324; amd. Sec. 7, Ch. 579, L. 1991; amd. Sec. 1, Ch. 293, L. 1993.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

1993 Amendment: Chapter 293 in (2)(b), at end, substituted "hospitalization" for "commitment"; in (2)(c), after "a description of", deleted "intermediate and long-range"; in (2)(d), after "achieving these", deleted "intermediate and long-range"; in (2)(e), at end, substituted "for attaining each treatment goal" for "and a description of proposed staff involvement with the patient in order to attain these treatment goals"; in (2)(f), after "conditions", deleted "and criteria for discharge"; deleted former (3) through (5) concerning content of treatment plan, supervision of treatment plan, and review of plan (see 1993 Session Law for text); inserted (3) concerning development, implementation, and supervision of plan by professional person; inserted (4) concerning reevaluation and revision of treatment plan; in (6) and (7) substituted "subsection (5)(c)" for "subsection (6)(c)"; and made minor changes in style.

1991 Amendment: Inserted (6), (7), and (8) granting patient certain rights relative to treatment plan.

Report to Legislature Required: Section 10, Ch. 579, L. 1991, required the Department of Institutions (now Department of Corrections) to submit a report to the 53rd Legislature concerning implementation of subsections (6)(c) through (8).
MCA 61.5-301, MT ST 61-5-301

MONTANA CODE ANNOTATED
TITLE 61. MOTOR VEHICLES
CHAPTER 5. DRIVER'S LICENSES
PART 3. MISCELLANEOUS PROVISIONS

61-5-301. Indication on driver's license of intent to make anatomical gift or of living will declaration

(1) The department of justice shall provide on each driver's license spaces for indicating when the licensee has:

(a) executed a document under 72-17-201 of intent to make a gift of all or part of the driver's body under the Uniform Anatomical Gift Act; or

(b) executed a declaration under 50-9-103 relating to the use of life-sustaining treatment.

(2) The department shall provide each applicant, at the time of application for a new driver's license or for a renewal, printed information calling the applicant's attention to the provisions of this section. Each applicant must be asked orally if the applicant wishes to make an anatomical gift and if the applicant has executed the declaration under 50-9-103 relating to the use of life-sustaining treatment.

(3) Each applicant must be given an opportunity to indicate in the spaces provided under subsection (1) the applicant's intent to make an anatomical gift or that the applicant has executed the declaration under 50-9-103 relating to the use of life-sustaining treatment.

(4) The department shall issue to each applicant who indicates an intent to make an anatomical gift a statement that, when signed by the licensee in the manner prescribed in 72-17-201, constitutes a document of anatomical gift. This statement must be printed on a sticker that the donor may attach permanently to the back of the donor's driver's license.

(5) The department shall electronically transfer the information of all persons who volunteer, upon application for a driver's license or an identification card, to donate organs or tissue to the organ and tissue donation registry created in 72-17-105 and 72-17-106 and any subsequent changes to the applicant's donor status.

History: En. 31-135.1 by Sec. 1, Ch. 28, L. 1977; R.C.M. 1947, 31-135.1; amd. Sec. 2, Ch. 459, L. 1985; amd. Sec. 1, Ch. 204, L. 1987; amd. Sec. 30, Ch. 443, L. 1987; amd. Sec. 2, Ch. 540, L. 1989; amd. Sec. 3, Ch. 230, L. 2003; amd. Sec. 1, Ch. 296, L. 2005.

Compiler's Comments

2005 Amendment: Chapter 296 inserted (1)(b) regarding executed declaration under 50-9-103; in (2) and (3) after "anatomical gift" inserted reference to declaration executed under 50-9-103; and made minor changes in style. Amendment effective October 1, 2005.

2003 Amendment: Chapter 230 in (5) substituted language requiring department to electronically transfer information on persons who volunteer to donate organs or tissue when applying for a driver's license or identification card to the registry for "The department shall also furnish the licensee a means of revoking the document of gift upon the license"; and made minor changes in style. Amendment effective October 1, 2003.

Preamble: The preamble attached to Ch. 230, L. 2003, provided: "WHEREAS, more than 80,000 people are currently waiting for life-saving organ transplants on the national transplant waiting list, of which 1,200 persons live in our region, and 17 people die each day as a result of the shortage of donated organs."

1989 Amendment: Near middle of (1) and in middle of (4) substituted reference to 72-17-201 for reference to 72-17-204.

1987 Amendments: Chapter 204 in (2), after "application", inserted "for a new driver's license or for a renewal" and inserted last sentence requiring Department to ask applicant orally whether anatomical gift is intended.

Chapter 443 near beginning of (1) substituted "driver's license" for "operator's or chauffeur's license". Amendment effective January 1, 1988.

1985 Amendment: Inserted (2) and (3) requiring department to provide information regarding
MCA 61.5-301, MT ST 61-5-301

anatomical gifts and to provide a space on operator's or chauffeur's license for indicating that licensee has executed document of intent to make anatomical gift.

MCA 61-5-301, MT ST 61-5-301

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
61-8-402. Blood or breath tests for alcohol, drugs, or both

(1) A person who operates or is in actual physical control of a vehicle upon ways of this state open to the public is considered to have given consent to a test or tests of the person's blood or breath for the purpose of determining any measured amount or detected presence of alcohol or drugs in the person's body.

(2) (a) The test or tests must be administered at the direction of a peace officer when:

(i) the officer has reasonable grounds to believe that the person has been driving or has been in actual physical control of a vehicle upon ways of this state open to the public while under the influence of alcohol, drugs, or a combination of the two and the person has been placed under arrest for a violation of 61-8-401;

(ii) the person is under the age of 21 and has been placed under arrest for a violation of 61-8-410; or

(iii) the officer has probable cause to believe that the person was driving or in actual physical control of a vehicle:

(A) in violation of 61-8-401 and the person has been involved in a motor vehicle accident or collision resulting in property damage; or

(B) involved in a motor vehicle accident or collision resulting in serious bodily injury, as defined in 45-2-101, or death.

(b) The arresting or investigating officer may designate which test or tests are administered.

(3) A person who is unconscious or who is otherwise in a condition rendering the person incapable of refusal is considered not to have withdrawn the consent provided by subsection (1).

(4) If an arrested person refuses to submit to one or more tests requested and designated by the officer as provided in subsection (2), the refused test or tests may not be given, but the officer shall, on behalf of the department, immediately seize the person's driver's license. The peace officer shall immediately forward the license to the department, along with a report certified under penalty of law stating which of the conditions set forth in subsection (2)(a) provides the basis for the testing request and confirming that the person refused to submit to one or more tests requested and designated by the peace officer. Upon receipt of the report, the department shall suspend the license for the period provided in subsection (6).

(5) Upon seizure of a driver's license, the peace officer shall issue, on behalf of the department, a temporary driving permit, which is effective 12 hours after issuance and is valid for 5 days following the date of issuance, and shall provide the driver with written notice of the license suspension and the right to a hearing provided in 61-8-403.

(6) (a) Except as provided in subsection (6)(b), the following suspension periods are applicable upon refusal to submit to one or more tests:

(i) upon a first refusal, a suspension of 6 months with no provision for a restricted probationary license;

(ii) upon a second or subsequent refusal within 5 years of a previous refusal, as determined from the records of the department, a suspension of 1 year with no provision for a restricted probationary license.

(b) If a person who refuses to submit to one or more tests under this section is the holder of a commercial driver's license, in addition to any action taken against the driver's noncommercial driving privileges, the department shall:

(i) upon a first refusal, suspend the person's commercial driver's license for a 1-year period; and

(ii) upon a second or subsequent refusal, suspend the person's commercial driver's license for life, subject to department rules adopted to implement federal rules allowing for license reinstatement, if the person is otherwise eligible, upon completion of a minimum suspension period of 10 years. If the person has a prior conviction of a major offense listed in 61-8-802(2) arising from a separate incident, the conviction has the same effect as a previous testing refusal for purposes of this subsection (6)(b).
(7) A nonresident driver's license seized under this section must be sent by the department to the licensing authority of the nonresident's home state with a report of the nonresident's refusal to submit to one or more tests.

(8) The department may recognize the seizure of a license of a tribal member by a peace officer acting under the authority of a tribal government or an order issued by a tribal court suspending, revoking, or reinstating a license or adjudicating a license seizure if the actions are conducted pursuant to tribal law or regulation requiring alcohol or drug testing of motor vehicle operators and the conduct giving rise to the actions occurred within the exterior boundaries of a federally recognized Indian reservation in this state. Action by the department under this subsection is not reviewable under 61-8-403.

(9) A suspension under this section is subject to review as provided in this part.

(10) This section does not apply to blood and breath tests, samples, and analyses used for purposes of medical treatment or care of an injured motorist or related to a lawful seizure for a suspected violation of an offense not in this part.

History: En. Sec. 1, Ch. 131, L. 1971; R.C.M. 1947, 32-2142.1; amd. Sec. 1, Ch. 103, L. 1981; amd. Sec. 1, Ch. 602, L. 1983; amd. Sec. 3, Ch. 659, L. 1983; amd. Sec. 8, Ch. 698, L. 1983; amd. Sec. 3, Ch. 99, L. 1985; amd. Sec. 1, Ch. 503, L. 1985; amd. Sec. 2, Ch. 789, L. 1991; amd. Sec. 1, Ch. 564, L. 1993; amd. Sec. 1, Ch. 444, L. 1995; amd. Sec. 6, Ch. 447, L. 1995; amd. Sec. 3, Ch. 88, L. 1997; amd. Sec. 1, Ch. 287, L. 1999; amd. Sec. 1, Ch. 213, L. 2003; amd. Sec. 13, Ch. 428, L. 2003; amd. Sec. 8, Ch. 556, L. 2003.

<General Materials (GM) - References, Annotations, or Tables>

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

2003 Amendments -- Composite Section: Chapter 213 in (2)(a)(iii)(A) after "damage" deleted "bodily injury, or death"; inserted (2)(a)(iii)(B) providing for the administration of tests if the officer has probable cause to believe that a person was driving a vehicle involved in an accident or collision resulting in serious bodily injury or death; and made minor changes in style. Amendment effective October 1, 2003.

Chapter 428 in (6)(a) at beginning inserted exception clause; inserted (6)(b) concerning suspension of a commercial driver's license if a licensee refuses to submit to tests; and made minor changes in style. Amendment effective October 1, 2003.

Chapter 556 in (5) near end after "suspension" deleted "or revocation"; in (6)(a) after "suspension" deleted "and revocation"; and in (6)(a)(ii) after "department" substituted "a suspension" for "a revocation". Amendment effective May 5, 2003.

Applicability: Section 23(3), Ch. 428, L. 2003, provided that this section applies to conduct or offenses that occur on or after October 1, 2003.

1999 Amendment: Chapter 287 in (5) after "which is" inserted "effective 12 hours after issuance and is"; and made minor changes in style. Amendment effective October 1, 1999.

Preamble: The preamble attached to Ch. 287, L. 1999, provided: "WHEREAS, in City of Helena v. Danichek, 277 Mont. 461, 922 P.2d 1170, 53 St. Rep. 767 (1996), a concurring opinion by Justice Nelson noted that section 61-8-402, MCA, requires that a drunk driver be issued a temporary driving permit as the driver leaves the police station and even before the driver is sober."

1997 Amendment: Chapter 88 in (1), near middle after "consent", deleted "subject to the provisions of 61-8-401", after "breath" deleted "or urine", and after "body" deleted "if arrested by a peace officer for driving or for being in actual physical control of a vehicle while under the influence of alcohol, drugs, or a combination of the two"; at end of (2)(a)(i) inserted "and the person has been placed under arrest for a violation of 61-8-401"; inserted (2)(a)(ii) requiring a test to be administered when the person is under the age of 21 and has been arrested; inserted (2)(a)(iii) requiring a test to be administered when the officer has probable cause to believe the person was driving under the influence and has been involved in an accident causing damage, injury, or death; in (2)(b), after "arresting", inserted "or investigating" and deleted second sentence that read: "A test for alcohol must be given first, whether or not that test also tests for drugs, and if the test shows an alcohol concentration of 0.10 or more, a test for drugs may not be given"; at beginning
of first sentence of (4) substituted "an arrested person" for "a driver under arrest", after "refuses" deleted "upon the request of a peace officer", after "submit to" substituted "one or more tests requested" for "a test or tests", before "officer" deleted "arresting", and after "provided in", substituted "subsection (2), the refused test or tests" for "subsection (1), a test" and in second sentence substituted language concerning a report certified under penalty of law stating the conditions for requesting and confirming the testing for "a sworn report noting that the peace officer had reasonable grounds to believe that the arrested person had been driving or was in actual physical control of a vehicle upon ways of this state open to the public while under the influence of alcohol, drugs, or a combination of the two and noting" and after "submit to" substituted "one or more tests requested and designated by the peace officer" for "the test or tests upon the request of the peace officer"; in (6) and (7) substituted "one or more tests" for "a test or tests"; inserted (10) providing that the section does not apply to blood and breath tests, samples, and analyses used for purposes of medical treatment or care of an injured motorist or related to a lawful seizure for a suspected violation not in the part; adjusted subsection references; and made minor changes in style.

1995 Amendments: Chapter 444 in (3), near beginning of second sentence after "shall", inserted "immediately", after "report" inserted "noting", and after "two and" inserted "noting"; near end of (4) substituted "5 days following the date of issuance" for "72 hours after the time of issuance" and at end inserted "and shall provide the driver with written notice of the license suspension or revocation and the right to a hearing provided in 61-8-403"; inserted (7) concerning seizure of license of tribal member and tribal court authority concerning license; and made minor changes in style. The amendment inserting subsection (7) is effective April 14, 1995, and the remainder of the amendments are effective October 1, 1995.

Chapter 447 in (5)(a) increased suspension from 90 days to 6 months; and made minor changes in style.

1993 Amendment: Chapter 564 throughout section, in six places after "test", inserted "or tests"; in first sentence of (1), after "alcohol", inserted "or drugs" and inserted fourth sentence regarding administration of tests; and made minor changes in style.

1991 Amendment: Throughout section inserted "drugs, or a combination of the two"; in first sentence of (1), in (3), and in (5), before "test", deleted "chemical"; in first sentence of (1) inserted reference to actual physical control, substituted "any measured amount or detected presence of alcohol in his body" for "the alcoholic content of his blood", and after "driving or" inserted "for being"; in (3) and (4), before "driver" and "driver's", deleted "resident"; in (6), at beginning, deleted "Like refusal by", after "nonresident" inserted "driver's license seized under this section", substituted "sent" for "subject to suspension", after "department" deleted "in like manner, and the same temporary driving permit shall be issued to nonresidents", and inserted final phrase referring to a report sent to licensing authority of nonresident's home state; and made minor changes in style.

1985 Amendments: Chapter 99 in (1) and (3) substituted "vehicle" for "motor vehicle" in four places.

Chapter 503 in (3) in three places, in (4), (5)(b), and (6) substituted references to department of justice for references to division of motor vehicles.

1983 Amendments: Chapters 602, 659, and 698 all changed "public highways of this state" to "ways of this state open to the public" throughout section, except that Ch. 698 used "the state". The Code Commissioner has chosen to use "this state".

Chapter 602 also made the following changes: in (3) near beginning of subsection changed "person" to "resident driver", after "but the" substituted language relating to seizure and forwarding of license through "along with" for "division, upon the receipt of", after "report" deleted "of the peace officer", at end of second sentence after "peace officer" deleted "shall suspend the license or driving privilege of such person on the highways of this state for a period of 60 days", and inserted last sentence requiring the department to suspend or revoke a driver's license upon receipt of a report of the driver's refusal to submit to a chemical test; inserted (4) requiring an officer, upon seizure of a driver's license, to issue a temporary driving permit, valid for 72 hours after issuance; inserted (5) establishing suspension and revocation periods upon refusal of a driver to submit to a chemical test; and in (6) after "manner" inserted remainder of subsection.

1981 Amendment: Substituted "alcohol" for
"intoxicating liquor" throughout.

Cross-References

Basis of opinion testimony by experts, Rule 703, M.R.Ev. (see Title 26, ch. 10).

Definition of vehicle, 61-1-101.

License reinstatement fee to fund county drinking and driving prevention programs, 61-2-107.

Authority of Department of Justice to suspend license or driving privilege, 61-5-206.

Definition of ways of this state open to the public, 61-8-101.

Case Notes

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CONSTITUTIONAL ISSUES

No Due Process Violation Based on Lack of Requirement Under Implied Consent Statutes to Provide Information Concerning Ramifications of Refusal to Take Breath Test: Turbiville, a North Dakota resident, was stopped in Montana for suspected DUI and was read a preliminary alcohol screening test advisory that outlined the right to refuse a breath test and the license suspension accompanying a refusal. He was provided no additional information concerning other rights regarding the preliminary breath test (PBT), particularly that Turbiville could refuse the test and challenge the license seizure in court. Turbiville took the PBT and an Intoxilyzer test, both of which indicated intoxication, and later moved to suppress the test results on grounds that the Montana implied consent statutes were misleading and inaccurate as applied to nonresidents. The motion was denied, and Turbiville appealed, asserting that if he had been advised of the right to a hearing to challenge the license seizure, he would have refused the PBT and that failure to provide an adequate advisory violated due process. The Supreme Court disagreed. The option to refuse a breath or blood test is not a matter of due process, but rather a matter of grace bestowed by the Legislature, and the Legislature may contour the favor in any manner considered appropriate. The implied consent statutes do not require an officer to provide information to an arrested motorist as to ramifications of the refusal to take a test, nor is a driver even entitled to be informed of the option to refuse the test. Further, by clear definition in 61-1-136, a driver's license includes a nonresident's driving privilege, so Turbiville's contention that the advisory was misleading on grounds that Montana had no authority to suspend a North Dakota driver's license also failed because the advisory was technically correct and accomplished the purpose of informing Turbiville of the potentially serious consequences of losing Montana driving privileges upon refusal to take a breath test. St. v. Turbiville, 2003 MT 340, 318 M 451, 81 P3d 475 (2003).

Administration of Breath Test Not Mandatory: Beanblossom was arrested for felony DUI and was read an implied consent advisory. When asked if he would consent to a breath test, Beanblossom consented, but the test was never administered. Beanblossom moved to dismiss the charge based on the officer's failure to administer the test, contending that the language of this section mandatorily required administration of the test, but does not mandate administration of the test. Thus, denial of Beanblossom's motion to dismiss was not erroneous. St. v. Beanblossom, 2002 MT 351, 313 M 394, 61 P3d 165 (2002). See also St. v. Entzel, 805 P2d 228 (Wash. 1991).

Arresting Officer's Advice Considered Frustration of Due Process Right to Independent Blood Test -- Strand Remedy for Violation of Due Process Rights Overruled: Minkoff was arrested for DUI and informed of his right to an independent

blood test. Minkoff asked the arresting officer whether he should get a blood test, and the officer initially replied that he could not advise Minkoff, but that the test would only be given at Minkoff's expense. Minkoff then asked whether there was any difference between the blood test and the breath test, and the officer repeatedly stated that the blood test would be more exact and higher than the breath test. Minkoff then took a breath test, which he failed, but did not request a blood test. After being convicted, Minkoff appealed on grounds that his right to an independent blood test was frustrated by the arresting officer's response to the inquiry whether to get a blood test. The District Court had relied on St. v. Sidmore, 286 M 218, 951 P2d 558 (1997), in denying Minkoff's motion to dismiss. Sidmore provides that two criteria must be met to support an allegation of denial of due process rights regarding the right to an independent test: (1) the accused must timely claim the right to an independent blood test; and (2) a law enforcement officer must unreasonably impede the defendant's right to obtain an independent blood test. Here, given the immediacy of the officer's advice, the period within which Minkoff could timely request the test under the first Sidmore criteria had not passed, and to conclude otherwise would permit frustration of a person's due process right to an independent test in advance of the person's reasonable opportunity to request the test. Then, to determine whether the officer unreasonably frustrated Minkoff's right to obtain the blood test, the Supreme Court applied Lau v. St., 896 P2d 825 (Alaska 1995). Under Lau, a government officer having custody of an arrested driver cannot attempt to dissuade the driver from exercising the right to an independent blood test. Here, the officer's repeated statements, albeit well-intentioned, that a blood test would show a higher blood alcohol level, were affirmative acts that would frustrate, if not obliterate, the intention of any rational arrests to obtain an independent blood test. Regarding the proper remedy for such a due process violation, the Supreme Court previously held in St. v. Strand, 286 M 122, 951 P2d 552 (1997), that suppression of the breath test was an appropriate remedy on the basis that if the state frustrated the right to an independent test, it could not then be allowed to use its own scientific evidence of intoxication against the defendant. On further consideration, the Supreme Court held that the Strand remedy was manifestly incorrect and overruled Strand in that regard, holding that dismissal rather than suppression of the breath test is the appropriate remedy when the right to an independent blood test is frustrated. St. v. Minkoff, 2002 MT 29, 308 M 248, 42 P3d 223 (2002).

Admissibility of Proof of Refusal to Take Sobriety Test Not Violative of Separation of Powers Doctrine: Robertson claimed that by enacting 61-8-404, regarding admission of evidence of a person's refusal to take a sobriety test, the Legislature unconstitutionally infringed on the function of courts to determine the admissibility of evidence, in violation of the separation of powers doctrine. The Supreme Court disagreed, noting that ultimately, the admissibility of evidence lies with the court pursuant to Rule 104, M.R.Ev. (Title 26, ch. 10). The Legislature routinely passes laws that determine whether certain kinds of evidence are admissible, without violating the separation of powers doctrine in the process. Further, "admissible" means that evidence may, but is not required, to be admitted. Missoula v. Robertson, 2000 MT 52, 298 M 419, 998 P2d 144, 57 St. Rep. 250 (2000). See also St. v. Long, 778 P2d 1027 (Wash. 1989).

Jury Trial Not Statutorily Mandated in Driver's License Suspension Case -- Not Violative of Right to Trial by Jury: Section 61-8-403 dictates that the court examine the facts and determine the merits of a petition challenging the suspension or revocation of a license but does not contemplate the role of a jury in the hearing, presuming instead that a jury will not be present, through assignment of tasks to the court. The in violate right to a trial by jury is not a prospective right that is automatically granted in every new proceeding that may arise. Rather, the right that is constitutionally preserved is that right to a jury trial that existed at the time that the constitution was enacted. There is not and has never been a right to a jury trial in purely equitable actions in Montana. Suspension or revocation of a driver's license pursuant to the implied consent law is a civil administrative sanction, not a criminal penalty, and is intended to protect the public rather than punish the driver. The hearing to determine the propriety of a driver's license suspension is an action in equity because compensatory or punitive damages are not allowed. Further, the reinstatement fee does not constitute a punishment that converts the equitable action into a criminal action because the fee is dedicated to the public purpose of funding county drinking and driving prevention programs. Therefore, a driver is not entitled to a trial by jury in a proceeding to determine the propriety of a driver's license suspension. Supola v. Dept. of Justice, 278 M 421, 925 P2d 480, 53 St. Rep. 984 (1996).

Punishment for Refusal to Take Breathalyzer Test and for Driving Under the Influence Not Double
Jeopardy: Danichek argued that he could not be convicted of driving under the influence because he had already been punished when his driver's license was suspended because he refused to take the Breathalyzer test and that to punish him for driving under the influence would constitute multiple punishments for the same offense. The Supreme Court held that Danichek's license was suspended for refusing the test and that it was the refusal that was a violation. That conviction had nothing to do with whether or not the person actually was driving under the influence, and therefore, he was being punished for two separate infractions and was not being placed in double jeopardy. *Helena v. Danichek*, 277 M 461, 922 P2d 1170, 53 St. Rep. 767 (1996), followed in *St. v. Ellenburg*, 283 M 136, 938 P2d 1376, 54 St. Rep. 532 (1997). In Ellenburg, the court was asked to overturn Danichek, and the court declined to do so.

Careless Handling of Blood Sample -- Deprivation of Due Process and Fair Trial: Defendant was taken to a hospital where a blood sample was drawn; then he was transported back to the Sheriff's office where he was booked and his personal property, including the blood sample, was taken from him. The blood sample was left on the counter in the dispatch room rather than being refrigerated and was not given to defendant upon his release. The Supreme Court held that once the sample was taken from defendant, the authorities had a duty to properly care for it. Since this duty was not performed, the careless handling of the sample deprived defendant of his due process right to gather possible exculpatory evidence, precluding a fair trial. *St. v. Swanson*, 222 M 357, 722 P2d 1155, 43 St. Rep. 1329 (1986), distinguished in *St. v. Heth*, 230 M 268, 750 P2d 103, 45 St. Rep. 194 (1988), and *St. v. Strand*, 286 M 122, 951 P2d 552, 54 St. Rep. 1333 (1997).

Refusal to Submit to Blood Alcohol Test Not Self-Incrimination: Use of evidence of a defendant's refusal to submit to a blood alcohol test in a DUI prosecution does not violate the defendant's United States Constitution fifth amendment right against self-incrimination. The language used in *Art. II, sec. 25, Mont. Const.*, is substantially identical to and affords no basis for interpreting it more broadly than its federal counterpart. Montana's constitutional prohibition against self-incrimination is not offended by the admission of defendant's refusal to submit to a Breathalyzer sobriety test. *St. v. Jackson*, 206 M 338, 672 P2d 255, 40 St. Rep. 1698 (1983).

**Defendant Informed of Right to Independent Blood Test After Administration of Portable Breath Test -- No Violation of Due Process Rights:** After Feldbrugge was stopped for speeding, the investigating officer noticed that Feldbrugge seemed confused, had difficulty removing his driver's license from his wallet and producing proof of registration and insurance, had bloodshot and glassy eyes and slurred speech, and was unsteady on his feet. The officer did not perform field sobriety tests, but did ask Feldbrugge to take a portable breath test (PBT). The officer read a short advisory that did not contain information regarding Feldbrugge's right to obtain an independent blood test to challenge the PBT results. Feldbrugge consented to the PBT, which he failed, and was arrested and taken to the county jail. Before being administered an Intoxilyzer breath test at the jail, Feldbrugge was read the informed consent advisory form, which included a statement regarding Feldbrugge's right to obtain an independent blood test. At trial, Feldbrugge moved to suppress the evidence on grounds that his due process rights were violated because he was not informed of the right to an independent blood test until after the PBT was administered. However, the notion that Feldbrugge had a choice between taking a PBT or obtaining an independent blood test, without penalty, was misguided. Here, it was unnecessary for the officer to inform Feldbrugge of the right to an independent blood test prior to requesting the PBT because even if Feldbrugge had been so informed, his options remained the same: consent to the PBT or refuse and have his driver's license seized. The officer was required to timely inform Feldbrugge that he could obtain an independent blood test in addition to the PBT and Intoxilyzer breath test so that Feldbrugge could gather exculpatory evidence. Informing Feldbrugge after the PBT was timely, so Feldbrugge's due process rights were not violated. Because the PBT results were admissible, Feldbrugge's arrest was supported by probable cause, and the DUI conviction was affirmed. *St. v. Feldbrugge*, 2002 MT 154, 310 M 368, 50 P3d 1067 (2002).

**District Court Proceeding Under Mistake of Law in Determining Whether Implied Consent Statute Applicable to Blood Drawn for Medical Reasons -- Supervisory Control Accepted:** The District Court suppressed the results of a blood test taken for medical reasons after a DUI suspect declined to give consent for a blood test following a car accident in which the use of alcohol was suspected. The Supreme Court concluded that the District Court was proceeding under a mistake of law, and that if the
mistake was left uncorrected, the state would be without an adequate remedy on appeal. Given the state's limited ability to appeal an evidentiary ruling, the Supreme Court accepted original jurisdiction in the matter to prevent the introduction of evidence when correction of the ruling by a later court decision would be ineffective. State ex rel. McGrath v. District Court, 2001 MT 305, 307 M 491, 38 P3d 820 (2001), following State ex rel. Mazurek v. District Court, 277 M 349, 922 P2d 474 (1996), and Park v. District Court, 1998 MT 164, 289 M 367, 961 P2d 1267 (1998).

No Burden-Shifting in Statute Allowing Evidence of Refusal to Take DUI Test: Relying on St. v. Long, 778 P2d 1027 (Wash. 1989), Robertson argued that 61-8-404(2) allows the prosecution to argue that an inference of guilt could be drawn from the evidence of his refusal to take a Breathalyzer test, impermissibly shifting the burden of proof to him to establish that the refusal was not a reflection of guilt, in violation of 46-16-204. Although the Washington and Montana versions of 61-8-404(2) are virtually identical, the Montana Supreme Court distinguished Long, finding nothing in the statute that inferred a consciousness of guilt arising from the introduction of evidence of the proof of refusal to take the test. The state still must prove the offense of DUI beyond a reasonable doubt. Missoula v. Robertson, 2000 MT 52, 298 M 419, 998 P2d 144, 57 St. Rep. 250 (2000).

Failure to Use Different Test Solution Than That Used in Prior Test in Testing Breathalyzer That Failed Prior Certification Test: Administrative rules require the state to use a fresh ethyl alcohol testing solution in retesting and certifying a Breathalyzer when the results of a prior test of the Breathalyzer are outside the range specified by the rules. The state did not do so and used the same solution as that used in the prior test. However, DUI defendant was not prejudiced thereby because the evidence showed that the problem was clearly with the Breathalyzer, not the solution. St. v. Woods, 285 M 124, 947 P2d 62, 54 St. Rep. 1074 (1997).

Issue of Suspension Absent Sworn Statement -- Not Properly Raised: In oral argument following the conclusion of the arresting officer's testimony, Thompson's counsel argued that Thompson's driver's license could not be suspended unless there was a sworn report as required under this section. The District Court properly declined to consider the issue as not having been properly raised or presented because: (1) neither the Department of Justice nor the County Attorney's office was given notice of the filing of the petition to review the license suspension; (2) no notice was given to the state or county that Thompson was raising an issue as to the filing of the proof of the sworn statement; and (3) neither the county nor the Department had an opportunity to present the actual report. Thompson v. Dept. of Justice, 264 M 372, 871 P2d 1333, 51 St. Rep. 272 (1994), followed in Gentry v. St., 282 M 491, 938 P2d 693, 54 St. Rep. 450 (1997).

Burden of Proof on Driver to Prove Invalidity of Revocation: Because there is a presumption of correctness to the state's action of revocation of a driver's license until otherwise shown to be improper, the burden of proof falls on the driver to prove the invalidity of the state's action rather than to require the state to justify its act of revocation. Jess v. St., 255 M 254, 841 P2d 1137, 49 St. Rep. 951 (1992), followed in In re License Revocation of Gildersleeve, 283 M 479, 942 P2d 705, 54 St. Rep. 735 (1997), and Kleinsasser v. St., 2002 MT 36, 308 M 325, 42 P3d 801 (2002).

Officers Unaware of First Refusal to Take Breathalyzer Test -- Privileges Reinstated After Ninety Days: The District Court did not err in reinstating after 90 days driving privileges suspended for 1 year, due to a second refusal to take a blood or Breathalyzer test, when officers who were unaware of a first refusal indicated the license would be suspended for only 90 days. In re Orman, 224 M 332, 731 P2d 893, 43 St. Rep. 2228 (1986).

Appeal of Driver's License Suspension -- Limited to Three Issues: The appeal under 61-8-403 of a driver's license suspension under 61-8-402 is limited to the following issues: (1) whether a police officer had reasonable grounds to believe the person had been driving or was in actual physical control of a vehicle upon the ways of this state open to the public while under the influence of alcohol; (2) whether the person was placed under arrest; and (3) whether the person refused to submit to the test. The implied consent law is a civil administrative proceeding separate and distinct from the criminal action on the charge of driving while intoxicated. Each proceeds independently of the other. Therefore, it was reversible error in an appeal of a driver's license suspension for the District Court to hold that petitioner's driver's license should not have been suspended because the initial stop of his vehicle was illegal. In re Blake, 220 M 27, 712 P2d 1338, 43 St. Rep. 143 (1986).

Implied Consent Suspension Not Relieved by

Guilty Plea: Respondent's license was suspended when he refused to take a breath test. Two weeks after arrest, respondent pleaded guilty to the offense of DUI. The District Court found that the plea of guilty constituted a withdrawal of his refusal to take breath test under the implied consent statute and recommended respondent receive a probationary license. Supreme Court reversed and reinstated suspension of respondent's license. The revocation of a driver's license is a civil sanction, not a criminal penalty, and there is no connection between the DUI statute and the implied consent statute. A violation of both statutes means the suspensions run concurrently. Respondent was not eligible for a probationary license until the 90-day implied consent suspension was completed. In re Petition of Burnham, 217 Mont. 513, 705 P.2d 603, 42 St. Rep. 1342 (1985), followed in In re Blake, 220 Mont. 27, 712 P.2d 1338, 43 St. Rep. 143 (1986), and Walker v. St., 229 Mont. 331, 746 P.2d 513, 705 P.2d 603, 42 St. Rep. 2008 (1987).

No Retroactive Application When Amended Statute Applied to Factual Situation Occurring Prior to Amendment: Section 61-8-402 was amended in 1983 to provide for a 1-year revocation of a driver's license upon the holder's refusal to submit to a chemical test within 5 years of a previous refusal. The court held that application of this provision, when the first refusal had occurred prior to the 1983 amendment, was not a retroactive application of law precluded by 1-2-109. Stiffarm v. Furois, 217 Mont. 335, 704 P.2d 75, 42 St. Rep. 1227 (1985).

ARRESTS AND INVESTIGATIVE STOPS

Sufficient Evidence to Support Particularized Suspicion to Justify Investigatory Stop -- Petition for Reinstatement of Driver's License Properly Denied: A highway patrol officer observed a vehicle swerve and hit the guardrail. The vehicle did not stop, so the officer followed the vehicle as it exited the freeway. The officer believed, in part, that the driver violated 61-7-108, failing to report an accident causing damage of $500 or more, so the officer stopped the vehicle and subsequently arrested Moore for DUI. When Moore refused a breath test, the officer seized Moore's driver's license. Moore petitioned for reinstatement of the license, arguing that the officer could formulate no suspicion that Moore was involved in wrongdoing that would warrant an investigative stop because the officer could not have known whether Moore was going to report the accident by the quickest means, which was for Moore to drive home and call. The District Court denied the petition, and the Supreme Court affirmed. The officer testified that the damage to the guardrail alone exceeded $500 and that Moore passed up at least two opportunities to stop and use a pay telephone to report the accident before the investigatory stop. Although the evidence conflicted, it was within the province of the District Court to determine the weight of the evidence and credibility of the witnesses. The officer testified credibly, and there was sufficient evidence in the record to indicate that the officer had the requisite particularized suspicion to justify the investigatory stop. Therefore, denial of Moore's petition to reinstate the driver's license was properly denied. Moore v. St., 2002 MT 315, 313 Mont. 126, 61 P.3d 746 (2002).

Authority for Arresting Out-of-Jurisdiction Peace Officer to Act Following Arrival of Officer With Jurisdiction: When a Belgrade police officer stopped a motorcycle under Bozeman after observing erratic driving and after the stop observed behavior indicative of intoxication, he was acting within his authority as a private citizen under 46-6-502. However, when the Bozeman police, whom he had contacted, arrived, the Belgrade officer's authority to act as a private citizen under 46-6-502 ceased and his performance of tests on the driver, placing him under arrest, transporting him to the jail, requests for a breath test, and writing of a citation, all in the absence of exigent circumstances, exceeded his citizen arrest authority under 46-6-502. Thus, the evidence obtained after the Bozeman police arrived was illegally obtained and must be suppressed in the DUI prosecution. To the extent that Maney v. St., 255 Mont. 270, 842 P.2d 704 (1992), suggests a contrary result, it is overruled. St. v. Hendrickson, 283 Mont. 105, 939 P.2d 985, 54 St. Rep. 516 (1997).

Intent to Arrest Formed After Person Physically Restrained After Failing to Stop as Requested -- Investigative Stop, Not Arrest: An officer had authority to arrest Anderson, whose walking and driving led her to believe that he was DUI. The officer restrained him with a "goose neck hold" when he failed to stop as requested. She testified without contradiction that it was not until after he resisted her hold and she could clearly identify the odor of intoxicants that she decided to arrest him for DUI. The request to stop and use of the gooseneck hold constituted an investigative stop, not an arrest. Anderson v. St., 275 Mont. 259, 912 P.2d 212, 53 St. Rep. 125 (1996).

Staggering Walk, Evasive Driving Without Turn Signals, and Failure to Stop When Requested While Later Walking as Grounds for Belief DUI Occurred:
An officer observed Anderson shuffling and staggering toward his car in Billings just before the bars closed. She did not see him get into the car. A few minutes later, she saw him driving in what she interpreted as an evasive manner and he failed to use turn signals. She lost track of him but later saw him walking in the same manner as before. He failed to stop when she told him to do so, and he had a strong odor of intoxicants. These circumstances created a particularized suspicion and reasonable grounds to believe that he may have been driving under the influence of alcohol. Anderson v. St., 275 M 259, 912 P2d 212, 53 St. Rep. 125 (1996), followed in Seyferth v. St., 277 M 377, 922 P2d 494, 53 St. Rep. 698 (1996).

Reasonable Cause for Arrest -- Citizen Informants Considered Presumptively Reliable: Facts and circumstances within an officer's personal knowledge (that plaintiff was in control of the vehicle in the parking lot) and facts imparted to him by three citizen informants (that plaintiff was intoxicated) were sufficient to warrant a reasonable person to believe that plaintiff was driving under the influence of alcohol. Information provided by citizen informants is considered presumptively reliable. Therefore, the officer had probable cause to arrest plaintiff, and the District Court did not err in suspending plaintiff's driver's license for 90 days. Santee v. St., 267 M 304, 883 P2d 829, 51 St. Rep. 1034 (1994), citing St. v. Sharp, 217 M 40, 702 P2d 959, 42 St. Rep. 1009 (1985), and St. v. Lee, 232 M 105, 754 P2d 512, 45 St. Rep. 903 (1988).

Arrest by Peace Officer Outside Officer's Jurisdiction -- Applicability of Driving Under the Influence Implied Consent Law: A peace officer is by statute "any person who by virtue of the person's office or public employment is vested by law with a duty to maintain public order and make arrests for offenses while acting within the scope of the person's authority". Though a city police officer's authority did not extend beyond the city limits and his arrest of a driver beyond the city limits for being under the influence could only be a citizen's arrest, he was within the definition of a peace officer even when outside the geographical area in which he had jurisdiction because he was at the time of the arrest a peace officer in fact and by virtue of holding the particular job. Therefore, the implied consent law applied even though it refers to a person "arrested by a peace officer". Maney v. St., 255 M 270, 842 P2d 704, 49 St. Rep. 980 (1992).

Lack of Formal Custody Transfer by Police Officer Outside Officer's Jurisdiction: Police officer followed beyond the Chinook city limits a vehicle he believed was driven by a person with a revoked license. He radioed for backup and stopped the vehicle after noticing it was moving slowly and erratically. The driver's breath smelled of alcohol, and after field sobriety maneuvers, the police officer and a Deputy Sheriff who had arrived agreed that the driver was impaired. The police officer then arrested the driver and delivered him to the Sheriff's office in Chinook. The police officer did not have to formally transfer custody to the Deputy Sheriff for the police officer's citizen's arrest to be legal. Maney v. St., 255 M 270, 842 P2d 704, 49 St. Rep. 980 (1992), overruled in St. v. Hendrickson, 283 M 105, 939 P2d 985, 54 St. Rep. 516 (1997).

Lack of Particularized Suspicion of Wrongdoing -- Seizure of License Improper: Because deputies who saw no evidence of erratic driving throughout their observation of Grinde's car lacked a particularized suspicion of wrongdoing on his part, the subsequent stop of his vehicle and the resulting arrest were illegal. Given these circumstances, the District Court properly returned Grinde's driver's license. Grinde v. St., 249 M 77, 813 P2d 473, 48 St. Rep. 586 (1991), clarifying Armstrong v. St., 245 M 420, 800 P2d 172, 47 St. Rep. 2057 (1990).

License Suspension Hearing a Civil Proceeding -- Requires Only Reasonable Belief That Defendant Under the Influence and in Control of Vehicle: The defendant was asleep in his vehicle with the motor running. The arresting officer smelled alcohol but did not administer any field sobriety tests. At the station house, the defendant refused to take a blood alcohol test. The Supreme Court ruled that a hearing to suspend an individual's driver's license is a civil proceeding and that the arresting officer only needs to show reasonable grounds to believe that the defendant was in control of the vehicle and under the influence of alcohol. Looking at the facts before it, the court ruled that the officer's belief that the defendant was in control of the pickup and under the influence was reasonable. Gebhardt v. St., 238 M 90, 775 P2d 1261, 46 St. Rep. 1114 (1989), followed in In re Turner v. St., 244 M 151, 795 P2d 982, 47 St. Rep. 1576 (1990).

Suspension of License Hearing -- Need Only Show Reasonable Belief Vehicle on Highway: A hearing to suspend an individual's license for refusing to take a blood alcohol test is a civil proceeding separate and distinct from the criminal DUI charge. The arresting officer need only show that he had
reasonable grounds to believe that the vehicle was on a way of the state open to the public. The Supreme Court ruled that considering statutory language and precedent, the officer had reasonable grounds to believe that the defendant's pickup, located approximately 10 feet from the traveled portion of the roadway, was on a way of the state open to the public. Gebhardt v. St., 238 M 90, 775 P2d 1261, 46 St. Rep. 1114 (1989), followed in Thompson v. Dept. of Justice, 264 M 372, 871 P2d 1333, 51 St. Rep. 272 (1994).

Arrest Required -- Capability of Refusal: An arrest is required before a blood sample may be taken pursuant to this section. When the record did not disclose that the defendant was incapable of refusal, a motion to suppress for failure to obtain the consent of the defendant was properly granted. St. v. Mangels, 166 M 190, 531 P2d 1313, 32 St. Rep. 177 (1975).

ADVICE OF RIGHTS AND DUTIES

Requirement That Officer Provide Certain Information to Person Lawfully Stopped for Investigation or Stop and Frisk: Prior to a hearing on his petition for reinstatement of his driver's license, which was revoked after his refusal to take a Breathalyzer test, Krause moved to suppress various statements made to the arresting officer. Krause argued that under Montana's stop and frisk statute, before asking where Krause had been and whether he had been drinking, the officer was required pursuant to 46-5-402(4) (now repealed) to inform Krause that he was a peace officer, that the stop was not an arrest but rather a temporary detention for investigative purposes, and that, unless arrested, Krause would be released upon completion of the investigation. The motion to suppress was denied, and Krause appealed. The state argued that 46-5-402(4) (now repealed) applied only if the officer had reason to suspect that Krause was armed and dangerous, as provided by 46-5-402(1) (now repealed), asserting that this was an investigatory stop governed by 46-5-401 rather than a stop and frisk governed by 46-5-402 (now repealed), and that because 46-5-401 does not contain the same information requirement as 46-5-402 (now repealed), it was not necessary that the officer inform Krause as required in 46-5-402(4) (now repealed). The Supreme Court agreed with Krause. By its terms, the stop and frisk statute clearly and unambiguously applies to the investigative stop statute as well. Therefore, a peace officer is also required to give the warning contemplated in 46-5-402(4) (now repealed) when a person is stopped for a DUI investigation, even when there is no intention to frisk, and the District Court erred when it did not suppress statements made by Krause prior to the officer giving the warning St. v. Krause, 2002 MT 63, 309 M 174, 44 P3d 493 (2002).

Allegation of Misinformation in Implied Consent Advisory Form as Applied to Nonresident -- Motion to Suppress Results of Breath Test Properly Denied: Ferguson pleaded guilty to driving under the influence of alcohol and driving the wrong way on a one-way street, but reserved his right to appeal the denial of his motion to suppress the evidence of his breath test. On appeal, Ferguson argued that the test results should have been suppressed because the implied consent advisory form misstated the law as it applied to him as a resident of Iowa and that he was thus unlawfully coerced into taking the breath test without having all the correct and relevant information upon which to make an informed decision. The Supreme Court affirmed the denial of the motion to suppress. The purposes of implied consent advisory forms are to put an apparently intoxicated driver on notice of the potentially serious consequences of refusing a blood alcohol test and to alert the driver of the due process protections germane to independent testing and posttesting hearings. Those purposes were accomplished here. Given that Ferguson's right to operate a motor vehicle faced suspension in both states because he refused to take the breath test and in light of the fact that he was told that his license would be returned to Iowa if he refused to take the test, his argument that he was misled or unlawfully coerced was unpersuasive. Missoula v. Ferguson, 2001 MT 69, 305 M 36, 22 P3d 198 (2001), following St. v. Simmons, 2000 MT 329, 303 M 60, 15 P3d 408 (2000).

Officer's Suspension of License Advice to Nonresident Driver Refusing Alcohol Testing Not Misleading -- Motion to Suppress Test Results Denied: Following an arrest for DUI, Simmons, a Nevada resident, was informed by the arresting officer that failure to comply with a request for a breath sample would result in possible seizure or suspension of his Nevada driver's license. In a motion to suppress the evidence, Simmons argued that the District Court had erred in denying his motion to suppress the breath test results because, since Montana had no authority to seize or suspend a Nevada license, his consent to the test was invalid because the officer provided erroneous and misleading information about the consequences of refusing testing. Simmons cited a Georgia decision, St. v. Coleman, 455 SE 2d 604 (Ga. App. 1995), in
which the Georgia court ruled that informing holders of out-of-state driver's licenses that they will lose driving privileges if they refuse blood alcohol testing constituted misinformation that justifies excluding from evidence any subsequent breath test results. Under Georgia law, drivers must be informed that the penalty for refusing a blood alcohol test is the loss of driving privileges "at least on the highways of this state". In affirming the District Court decision, the Supreme Court adopted the reasoning of the three-judge minority in Coleman, ruling that the advisory read to Simmons was technically correct in informing him that failure to submit to a blood alcohol test would result in the seizure and suspension of his driver's license. If a person refuses a testing request, Montana law specifically authorizes the Department of Justice to suspend or revoke nonresident driving privileges and to forward the seized license, along with a report of the testing refusal, to the licensing authority of the nonresident's home state. Since by definition a driver's license includes "any nonresident's driving privilege", the advisory read to Simmons informing him that his driver's license would be seized and suspended was technically correct. St. v. Simmons, 2000 MT 329, 303 M 60, 15 P3d 408, 57 St. Rep. 1393 (2000).

Due Process Requires Individuals to Be Informed of Right to Independent Blood or Breath Test -- Remedy for Failure to Inform Is Suppression of State's BAC Evidence: Strand argued that his due process right to obtain exculpatory evidence had been denied by the Kalispell Police Department's policy to not inform an individual of the right to an independent blood or breath test when the individual consents to the test designated by the arresting officer. The Supreme Court held that due process requires the arresting officer to inform the individual of the right to an independent test regardless of whether the accused consents to the test designated by the officer. The Supreme Court further held that the appropriate remedy for the state's failure to inform Strand of his rights was to suppress the state's BAC evidence because the failure to inform negated the informed consent provisions of state law. St. v. Strand, 286 M 122, 951 P2d 552, 54 St. Rep. 1333 (1997), overruled in St. v. Minkoff, 2002 MT 29, 308 M 248, 42 P3d 223 (2002).

Refusal to Take Breathalyzer Test -- Driver Properly Informed of Options and Consequences: Ellenburg contended that his driver's license was improperly suspended because he had been misinformed of the consequences of not taking the breath test and was led to believe that a blood test would satisfy the implied consent statute despite his refusal to take a breath test. However, a review of the videotape of the DUI booking showed that the arresting officer clearly explained that the breath test was being offered as the designated test under the implied consent statute. The officer was not required to request a breath test from Ellenburg because the offered breath test had already been refused. Ellenburg's petition for reinstatement of his driver's license was properly denied. Ellenburg v. Dept. of Justice, 280 M 268, 929 P2d 861, 53 St. Rep. 1398 (1996), distinguishing In re Orman, 224 M 332, 731 P2d 893 (1986).

"Confusion Doctrine" Inapplicable: Stopped for suspicion of driving under the influence, appellant was read the implied consent form and asked to submit to a blood alcohol content (BAC) test. After appellant refused, the officer read appellant's Miranda rights and allowed appellant to call an attorney. Subsequently, appellant's license was suspended for refusing to submit to the BAC test. Appealing the suspension, appellant argued that the BAC test refusal should be excused because the officer's failure to inform appellant that a driver has no right to counsel before deciding whether to submit to the BAC test caused appellant to confuse his Miranda right to counsel with rights under the implied consent law. While not adopting the "confusion doctrine", the Supreme Court ruled that it applies only when Miranda rights are given prior to or contemporaneously with a driver being informed of rights under the implied consent law. Since appellant's Miranda rights were given after the implied consent form was read and after the driver's refusal to submit to the BAC test, it was unlikely that appellant confused the Miranda right to counsel with rights under the implied consent law. In re Suspension of Driver's License of Blomeyer v. St., 264 M 414, 871 P2d 1338, 51 St. Rep. 324 (1994), followed in Gentry v. St., 282 M 491, 938 P2d 693, 54 St. Rep. 450 (1997), and distinguished in Williams v. St., 1999 MT 5, 293 M 36, 973 P2d 218, 56 St. Rep. 20 (1999).

INDEPENDENT, FORCED, AND REFUSED TESTS

When Right to Obtain Independent Blood Test Unreasonably Impeded -- No Due Process Violation - - Swanson Rule Clarified: One accused of a crime involving intoxication is entitled to obtain an independent blood test only when: (1) the defendant has timely claimed the right to an independent blood test; and (2) a law enforcement officer has unreasonably impeded the defendant's right to obtain
an independent blood test. Both criteria must be satisfied in order to support an allegation of violation of a defendant's due process rights. The rule does not apply either if the defendant fails to timely request the independent blood test or if the independent blood test is unavailable through no unreasonable acts of law enforcement. In the present case, Sidmore's due process rights were not violated because the unavailability of an independent blood test was not caused by an unreasonable act of law enforcement but rather by Sidmore's own failure to act after requesting and being given the opportunity to arrange an independent blood test. St. v. Sidmore, 286 M 218, 951 P2d 555, 54 St. Rep. 1381 (1997), clarifying St. v. Swanson, 222 M 357, 722 P2d 1155 (1986), and distinguishing St. v. Strand, 286 M 122, 951 P2d 552, 54 St. Rep. 1333 (1997). See also St. v. Minkoff, 2002 MT 29, 308 M 248, 42 P3d 223 (2002).

Negligent Vehicular Assault -- Blood Sample Evidence Drawn in Violation of Statute Not Admissible: Defendant was arrested for negligent vehicular assault and refused to give a blood sample for determination of blood alcohol content. The sample was forcibly taken. The District Court suppressed the blood alcohol evidence, and the Supreme Court affirmed. Because the DUI offense set forth in 61-8-401 is a specific element of and is subsumed in the negligent vehicular assault offense, defendant was "arrested by a peace officer for driving or for being in actual physical control of a vehicle while under the influence of alcohol". Therefore, this section prohibited the state from forcibly giving the blood test after refusal to submit to it, and the blood sample evidence was drawn in violation of the statute and was inadmissible. St. v. Stueck, 280 M 38, 929 P2d 829, 53 St. Rep. 1288 (1996).

Willing but Unable Participant in Alcohol Test -- Meaning of "Test or Tests" as Single Test for Alcohol -- Psychological Inability to Perform: Wessell consented to a breath test, but two attempts failed because of the failure of the internal standards check for the test instrument. He was asked to submit to a blood test but immediately refused based on his great fear of needles. He volunteered to take a urine test, but the offer was refused because the police department had no way to preserve the integrity of a test sample. Wessell declined to have an independent test completed because he believed that his driving privileges would be suspended regardless as a result of his failure to submit to a blood test. The officer completed the refusal affidavit and seized Wessell's license. On appeal, Wessell claimed that this section does not expressly authorize more than one test for alcohol to which he gave consent. However, the state claimed that the language "test or tests" in subsection (3) allows consecutive tests for alcohol and that Wessell refused to submit to the alternate blood test. The Supreme Court concluded that the plural language added to the statute refers to the sequential testing for alcohol and then drugs, not for consecutive tests for alcohol alone. However, the alcohol test must be a full and complete analysis. Because the breath test was not completed, it was not valid, so the officer was within the statutory constraints when designating a second method of testing to achieve a valid alcohol test. Although certain uncooperative actions by a motorist may comprise a refusal, Wessell was fully cooperative but was unable to submit to the blood test because of a valid, disabling fear of needles. This psychological inability to perform the test was the equivalent of a physical disability precluding Wessell from completing a valid test regardless of his willingness. The District Court erred in concluding that Wessell's inability to participate in the test regardless of his willingness constituted a refusal warranting license suspension, and thus the case was reversed and remanded. Wessell v. St., 277 M 234, 921 P2d 264, 53 St. Rep. 610 (1996).

Arrest Not Required for Nonconsensual Blood Sample Without Warrant -- No Fourth Amendment Violation: While administering first aid to plaintiff injured in a motorcycle accident, rangers noticed telltale signs of alcohol use and requested that plaintiff submit to a Breathalyzer test. After plaintiff refused, park rangers instructed the medic to withdraw a sample of blood while administering an emergency I.V. Based largely on the blood sample, plaintiff was subsequently convicted of drunk driving. On appeal, a three-judge panel reversed the conviction, concluding that under U.S. v. Harvey, the rangers' failure to arrest the plaintiff before or shortly after obtaining the blood sample rendered the seizure unreasonable under the fourth amendment. On review, the Ninth Circuit Court vacated the conviction, holding that the fourth amendment does not require a suspect's arrest for officers to obtain a blood sample without consent or a warrant. U.S. v. Chapel, 55 F3d 1416 (9th Cir. 1995), expressly overruling U.S. v. Harvey, 701 F2d 800 (9th Cir. 1983), which held that the fourth amendment requires authorities to arrest a suspect prior to a nonconsensual taking of blood without a warrant.

Failure of City to Comply With Request for DUI Independent Blood Test -- Due Process Violation: Defendant timely requested an independent blood test
Hunter did not clearly withdraw her former refusal. Citing Johnson v. Div. of Motor Vehicles, 219 M 310, 711 P2d 815 (1985), the Supreme Court also held that the arresting officer was not bound to accept a withdrawal of the earlier refusal. Hunter v. St., 264 M 84, 869 P2d 787, 51 St. Rep. 158 (1994).

Independent Sobriety Test -- Failure to Obtain Test Not Violation of Due Process if Test Not Requested: When the defendant failed to request an independent sobriety test, even though the defendant at one point stated that he wanted a test to be performed by his own doctor, the District Court was not clearly erroneous in determining that the defendant's due process rights were not violated. The mere fact that an independent sobriety test was not obtained was not a violation of a defendant's due process rights. St. v. Klinkhammer, 256 M 275, 846 P2d 1008, 50 St. Rep. 92 (1993).

Swanson Rule Limited -- No Police Duty to Assist in Obtaining Exculpatory Evidence: The rule set out in St. v. Swanson, 222 M 357, 722 P2d 1155, 43 St. Rep. 1329 (1986), applies only when: (1) the defendant has timely claimed the right to a blood test; and (2) the officer does not unreasonably impede the defendant's right to a blood test. Police officers have no affirmative duty to assist in gathering exculpatory evidence or may they frustrate such efforts on the part of the accused. St. v. Clark, 234 M 222, 762 P2d 853, 45 St. Rep. 1859 (1988).

Officer's Persistence in Obtaining Blood Sample Pursuant to Search Warrant -- Within Scope of Employment: Collins was arrested for DUI but refused to submit to a chemical test. Upon learning that Collins was on probation for a prior DUI and for other non-DUI offenses, the arresting officer obtained a search warrant authorizing extraction of a blood sample. Collins later filed an action alleging assault and battery and violation of his constitutional rights. The District Court found the officer acted outside the scope of his employment and that the blood sample was unauthorized and contrary to subsection (3) of this section. The Supreme Court reversed, finding it was clear the officer acted as he did to preserve evidence relating to non-DUI offenses and acted within the scope of his employment. Where law enforcement authorities have probable cause to believe an offense other than an underlying DUI has occurred for which a blood test is required to preserve evidence, a blood sample may be taken pursuant to a search warrant. Collins v. St., 232 M 73, 755 P2d 1373, 45 St. Rep. 878 (1988).
Right to Independent Blood Test in Crime Involving Intoxication: The state interpreted 61-8-405 to mean that the right to an independent blood test arises only after an accused takes a test designated by the arresting officer. The Supreme Court, citing an Arizona Appellate Court interpretation of an identical statute, found that such an interpretation would result in an unconstitutional restraint on the right of a criminal accused to attempt to obtain independent evidence of his innocence and deprive him of due process of law (Smith v. Cada, 562 P2d 390 (Ariz. App. 1977)). Therefore, it was held that a person accused of a crime involving intoxication has a right to obtain an independent blood test to establish his sobriety regardless of whether he submits to a police designated test under 61-8-402, St. v. Swanson, 222 M 357, 722 P2d 1155, 43 St. Rep. 1329 (1986), distinguished in Walker v. St., 229 M 331, 746 P2d 624, 44 St. Rep. 2008 (1987), on grounds that defendant Walker was subject to civil penalty under this section, not criminal penalty under 61-8-405.

Taking Test After Refusal of Test -- No Cure of Refusal: Police officer informed driver three times that officer was requesting a Breathalyzer test. Each time driver asked if he could have an attorney present and was told he did not have that right. Each time driver failed to take the test. He may have been confused by the apparent conflict between his stated Miranda rights and the lack of a right to have an attorney present during the test, and he did not expressly refuse to submit to a test. About twenty minutes later, a doctor took a blood test at driver's request. Driver's attorney gave the results, showing a 0.20 blood alcohol level, to the prosecution. Driver's license was properly seized on his failure to take the requested test, and the later test did not cure driver's failure to take the requested test. It is refusal to take the test the officer requests that triggers automatic license suspension, and no code section allows a withdrawal or cure of a refusal. The driver's conduct and statements were an implied refusal. Any Miranda-warning confusion on driver's part was irrelevant when the officer told him he had no right to have an attorney present during a blood test. Johnson v. Div. of Motor Vehicles, 219 M 310, 711 P2d 815, 42 St. Rep. 2045 (1985), followed in Meyer v. St., 229 M 199, 745 P2d 694, 44 St. Rep. 1900 (1987), Walker v. St., 229 M 331, 746 P2d 624, 44 St. Rep. 2008 (1987), and In re Suspension of Driver's License of Blomeyer v. St., 264 M 414, 871 P2d 1338, 51 St. Rep. 324 (1994).

Test to Be Designated by Arresting Officer: The District Court did not err in refusing to reinstate appellant's driving privileges that were suspended when appellant refused to take a breath test and insisted on a blood test. If an arrested person chooses to take a chemical test other than the test designated by the arresting officer and will not take the designated test, it is a refusal for which his driver's license will be suspended. (See 1993 amendment.) St. v. Christopherson, 217 M 449, 705 P2d 121, 42 St. Rep. 1320 (1985).

No Choice as to Type of Test -- Jurisdiction on Appeal: The District Court did not err in denying appellant's motion to reinstate driving privileges. Appellant's insistence on taking a blood test and refusing breath test constitutes a refusal for purposes of suspending driving privileges. Requiring appellant to take a breath test was not a denial of due process. Appellant's notice of appeal that referred only to the motion to dismiss the criminal matter (the charge of DUI) was sufficient notice of appeal of the civil issue (reinstatement of driving privileges) to confer jurisdiction over the civil matter when both issues were in the same District Court order. St. v. Logan, 217 M 446, 705 P2d 123, 42 St. Rep. 1317 (1985), overruled by St. v. Swanson, 222 M 357, 722 P2d 1155, 43 St. Rep. 1329 (1986). See St. v. Peterson, 227 M 503, 741 P2d 392, 44 St. Rep. 1198 (1987).

Section Not Applicable to Negligent Homicide Prosecutions: This section's prohibition against nonconsensual extractions of blood samples does not apply to prosecutions for negligent homicide under 45-5-104. Therefore, it was proper to admit into evidence at defendant's trial on the charge of negligent homicide the results of a blood test performed without his consent. St. v. Thompson, 207 M 433, 674 P2d 1094, 41 St. Rep. 57 (1984), distinguished in St. v. Stueck, 280 M 38, 929 P2d 829, 53 St. Rep. 1288 (1996).

"In a Condition Rendering Him Incapable of Refusal": Investigating highway patrolman saw driver at scene of collision in which two persons in another auto were killed, received a blank stare when he questioned driver, saw driver in intensive care in hospital 2 hours later, with his eyes closed, lying on a bed with i.v.s being administered, and was told by a doctor that he could not speak to driver. Even though driver was conscious and apparently coherent, his physical condition was serious enough to render him incapable of refusing to consent to a blood test, and results of test made after the doctor authorized a nurse to draw blood from driver and give it to the patrolman were properly admitted in negligent

Rumley appealed his conviction for negligent homicide in connection with a motor vehicle accident. A sample of Rumley's blood was taken after the accident, and he filed a motion to suppress the results of a blood alcohol test. There was testimony that Rumley was confused and disoriented after the accident. Rumley suffered a fractured jaw, a broken foot, and numerous other injuries. In light of this evidence of incapacity, the District Court properly denied the motion to suppress, and the officer at the hospital, unable to receive a coherent response from Rumley, properly requested that a blood sample be taken. **St. v. Rumley**, 194 M 506, 634 P2d 446, 38 St. Rep. 1351A (1981).

**Properly Taken Blood Test**: Applying the standard in **St. v. Mangels**, 166 M 190, 531 P2d 1313 (1975), that "...incapacity be determined on the basis of the best evidence which is reasonably available to the officer...", the Supreme Court found that defendant was in a condition rendering him incapable of refusing to consent to the taking of a blood sample. Thus, it was unnecessary for him to be placed under arrest prior to the blood sample taking. This result was held to be consistent with the implied consent statute and the fourth amendment protection against unlawful searches. The latter issue was addressed in **St. v. Deshner**, 158 M 188, 489 P2d 1290 (1971), **St. v. Campbell**, 189 M 107, 615 P2d 190, 37 St. Rep. 1337 (1980).

**RIGHT TO COUNSEL**

No Right to Counsel Prior to Taking Breath Test -- Implied Consent: A person does not have a right to consult with counsel prior to deciding whether to take an alcohol breath test because consent is considered given as a matter of law pursuant to this section. **St. v. Van Kirk**, 2001 MT 184, 306 M 215, 32 P3d 735 (2001).

Confusion About Need for BAC Test Once PAST Taken -- Refusal to Extend Confusion Doctrine: Williams was stopped by a Deputy Sheriff for driving erratically and consented to a preliminary alcohol screening test (PAST), which she failed. The Deputy Sheriff then arrested her and took her to the Eureka police station. There, Williams was read the implied consent advisory form informing her that if she did not submit to a blood alcohol concentration (BAC) test, her driver's license would be confiscated. Williams refused to submit to a BAC test, and the confiscation of her license was upheld by the District Court. Before the Supreme Court, Williams claimed that an extension of the "confusion doctrine" should be held to apply to her case. The Supreme Court held that the confusion doctrine, discussed by the Supreme Court in **Blomeyer v. St.**, 264 M 414, 871 P2d 1338 (1994), and **Gentry v. Dept. of Justice**, 282 M 491, 938 P2d 693 (1997), and under which refusal to submit to the BAC may be excused if a driver is given a Miranda warning first and is therefore confused as to whether the driver has a right to an attorney before submitting to the BAC, would not be extended to a situation such as Williams's, in which it was claimed that confusion existed as to the necessity for the BAC if the PAST has already been administered. Williams v. St., 1999 MT 5, 293 M 36, 973 P2d 218, 56 St. Rep. 20 (1999).

**No Right to Counsel Before Deciding Whether to Submit to Chemical Testing -- Blood Alcohol Test Not "Critical Stage" Event, Self-Incriminating Communication, or Denial of Due Process**: Defendant was arrested on a charge of driving while under the influence of alcohol. He agreed to a chemical test after being told that he had a right to refuse the test and that he did not have a right to consult an attorney before deciding whether to submit to testing. The District Court granted the defendant's motion to suppress the results of the test on the basis of the 6th and 14th amendments to the U.S. Constitution. The Supreme Court reversed and found that neither the U.S. Constitution nor the Montana Constitution guarantees a defendant the opportunity to seek an attorney's advice before deciding whether to submit to a blood alcohol test, when consent is considered given as a matter of law. A Breathalyzer test is not susceptible to the suggestive manipulation characteristic of the "critical stage" event, the results of the test are not self-incriminating communications, and the statutory procedures for the test meet due process requirements. **St. v. Armfield**, 214 M 229, 693 P2d 1226, 41 St. Rep. 2430 (1984), followed in **Meyer v. St.**, 229 M 199, 745 P2d 694, 44 St. Rep. 1900 (1987), **In re Suspension of Driver's License of Blomeyer v. St.**, 264 M 414, 871 P2d 1338, 51 St. Rep. 324 (1994), and **St. v. Van Kirk**, 2001 MT 184, 306 M 215, 32 P3d 735 (2001).

**TEMPORARY LICENSE**

Appeal Not Allowing for Reinstatement of License Because of Officer's Failure to Issue Temporary License: An appeal under 61-8-403 does not allow for reinstatement of a driver's license because of an officer's failure to issue a temporary

LICENSE SUSPENSION

Issues for Consideration in Petition for Review of Seizure of Driver's License: As established in Bush v. Dept. of Justice, 1998 MT 270, 291 M 359, 968 P2d 716 (1998), the three issues to be determined by a District Court in a petition for review of a seizure of a driver's license are whether: (1) the arresting officer had a particularized suspicion that a person was driving or in actual control of a vehicle on the ways of this state while under the influence of alcohol or drugs; (2) the petitioner was lawfully under arrest, including the existence of probable cause; and (3) the petitioner in fact declined to submit to a breath test. In this case, Widdicombe contested the first two determinations, but the Supreme Court affirmed. While leaving town on a two-lane highway, the arresting officer and another officer in the patrol car observed Widdicombe crossing the center lane three times, in violation of 61-8-321, and this fact was corroborated by videotape evidence. Thus, Widdicombe failed to meet the burden of proving a lack of particularized suspicion for the initial stop. Further, it was not necessary for the arresting officer to testify to probable cause when another officer witnessed the event and testified. Thus, Widdicombe failed to prove that the officers did not have probable cause for the arrest. Widdicombe v. State ex rel. LaFond, 2004 MT 49, 320 M 133, 85 P3d 1271 (2004), distinguishing St. v. Lafferty, 1998 MT 247, 291 M 157, 967 P2d 363 (1998).

Challenge to Driver's License Suspension Considered Special Proceeding -- Successful Defendant Entitled to Costs: Neal's driver's license was suspended for failure to take a breath test. Neal challenged the suspension, claiming that he did not refuse to take a breath test, and the District Court agreed. Neal's license was reinstated and Neal was granted costs. The state objected to the award of costs, and the District Court amended the original order and denied costs, so Neal appealed. Neal contended that as the prevailing party, an award of costs was proper under 25-10-101(2) because the license was valued at more than $50 or under 25-10-101(4) because the petition to reinstate the license was a special proceeding. The state contended that the particular provisions of 25-10-711 prevailed over the general provisions of 25-10-101, so 25-10-101 did not apply. The Supreme Court disagreed, finding no inconsistency between the statutes. Section 25-10-711 applies to actions in which a party prevails against a government entity and can establish that the government's claim or defense was frivolous or pursued in bad faith, but no such finding is required for recovery of costs under 25-10-101. The court went on to find that Neal's claim that costs were proper based on the license value was unfounded, because no finding of valuation was ever determined. However, the court concluded that a challenge to a driver's license suspension or revocation was a special proceeding pursuant to 27-1-102, and that as the prevailing party in the action, Neal was entitled to costs pursuant to 25-10-101. Neal v. St., 2003 MT 53, 314 M 357, 66 P3d 280 (2003).

DUI Suspension or Revocation Clarified -- Law of Case Doctrine and Collateral Estoppel Inapplicable -- Contempt Order Refused: Sanders was arrested for a second DUI in a 5-year period and filed an action in District Court seeking review of the facts of the arrest. The District Court and the Supreme Court upheld the arrest and noted that a 6-month suspension of Sanders' license would take place. Later, after the Department of Justice refused to reinstate the license after the 6-month period expired because this section applied and required a revocation of Sanders' license for 1 year, Sanders brought a contempt action in the District Court asking that the Department be held in contempt for failure to reinstate his license after expiration of the 6-month period. Sanders argued that the 6-month period had become the law of the case and that the failure of the Department to follow that law was a contempt of the District Court. After reviewing the records of the District Court and its own record in the previous DUI action, the Supreme Court held that the law of the case doctrine was inapplicable. Citing Haines Pipeline Constr., Inc. v. Mont. Power Co., 265 M 282, 876 P2d 632 (1994), and Scott v. Scott, 283 M 169, 939 P2d 998 (1997), the Supreme Court explained that the law of the case doctrine applies only to the rulings of a court that are necessary to the decision and, in the case of the District Court's and Supreme Court's prior ruling in Sanders' DUI conviction, a determination that only a 6-month suspension was required under this section was not necessary to either the District Court's or the Supreme Court's prior ruling. Those rulings, the Supreme Court said, concerned only whether the arresting officer had probable cause for the arrest. Thus, the Supreme Court held, the reference to a 6-month suspension in the previous opinions was dicta, there was no law of the case determined concerning the law governing license suspension or revocation, and therefore there could be no contempt for failure.
to reinstate Sanders' license. The Supreme Court also held that collateral estoppel was likewise inapplicable to require the Department to reinstate the license because collateral estoppel applies only to previously litigated issues and the period of license suspension or revocation of Sanders' license had not been previously litigated. Sanders v. St., 1998 MT 62, 288 M 143, 955 P2d 1356, 55 St. Rep. 272 (1998).

Failure to Seize License -- Not Fatal to Enforcement of Statute: When, under this statute, an arresting officer fails to seize an individual's driver's license and fails to issue a 72-hour temporary driving permit to a driver who refuses to take the Breathalyzer test, the state may suspend the driver's license. An arresting officer's error in enforcing certain provisions of the statute does not automatically preclude enforcement of the entire statute. (See 1995 amendment.) In re Vinberg, 216 M 29, 699 P2d 91, 42 St. Rep. 615 (1985).

No Due Process Right to Presuspension Hearing: The defendant was arrested for driving under the influence of alcohol. The arresting officer initially seized the defendant's driver's license, then later returned it after the defendant refused to take the Breathalyzer test. The officer failed to issue a 72-hour temporary driving permit. (See 1995 amendment.) The Motor Vehicle Division subsequently suspended the defendant's driver's license. The defendant then petitioned for a hearing on the suspension issue. Although 61-8-402 and 61-8-403 provide a mechanism for a hearing before suspension, in this case the defendant's license was suspended before he had a hearing. Following the decision in Mackey v. Montryn, 443 US 1, 61 L Ed 2d 321, 99 S Ct 2612 (1979), the Montana Supreme Court held that deprivation of a driver's license does not require a presuspension hearing. Due process is satisfied by a prompt postsuspension hearing. In re Vinberg, 216 M 29, 699 P2d 91, 42 St. Rep. 615 (1985).

EVIDENCE ISSUES

Ample Evidence That DUI Suspect Had Been Driving on Public Road Even Though Parked in Private Driveway: Krause was discovered parked in the driveway of a private residence, asleep on the seat of his truck with his feet resting on the floor under the steering wheel. Krause was arrested for DUI but declined to take a Breathalyzer test, so his license was suspended. Krause petitioned for reinstatement of the license, arguing that revocation of the license under the implied consent statute was improper because Krause was not on a way of this state open to the public at the time of his arrest. The District Court denied the petition, finding that the lane or access road providing access to the residence was a way of this state open to the public. Krause appealed, but without reaching the issue of whether the driveway was considered a public way, the Supreme Court affirmed. Krause's truck did not suddenly materialize out of thin air in the driveway; Krause had to have driven it there by way of the highway that was only 20 or 30 feet from the driveway. Because Krause had been parked only a few minutes before the officer arrived, Krause's intoxicated condition had to have occurred prior to Krause's arrival at the residence. Thus, the officer had reasonable grounds to believe that Krause had been driving on the highway while under the influence. St. v. Krause, 2002 MT 63, 309 M 174, 44 P3d 493 (2002), distinguishing St. v. Haws, 869 P2d 849 (Okla. Crim. App. 1994).

Error in Not Excluding Results of Independent Blood Alcohol Test Taken After DUI Arrestee Released From Custody: When Krause was picked up for DUI, he refused to take a Breathalyzer test and his license was revoked. After booking, Krause was released from custody, went to the hospital, and requested a blood alcohol test. The state subsequently obtained the results of the blood test by investigative subpoena, and the District Court allowed admission of the test results at Krause's trial over his objection. Krause appealed on grounds that the test results should not have been admitted because they were not relevant to any issue in the case. Krause pointed out that the decision as to the validity of an arrest must be based on information that the officer had at the time and cannot be justified bolstered by information obtained after the fact. The state argued that the evidence of the blood test was introduced to substantiate the credibility of the arresting officer's observations and opinion, not to retrospectively validate the officer's belief that Krause had been driving under the influence. The Supreme Court agreed with Krause. The officer's character for truthfulness was not attacked, nor did evidence of Krause's blood test refer to the officer's character for truthfulness. Thus, there was no legitimate purpose for the introduction of the blood test evidence, and the District Court should have excluded it. St. v. Krause, 2002 MT 63, 309 M 174, 44 P3d 493 (2002).

Blood Test Results From Emergency Medical Treatment Admissible as DUI Evidence Notwithstanding Lack of Consent to Blood Test: Llewellyn was involved in an automobile accident, sustaining significant injuries. Llewellyn was asked
to submit to a blood test at the accident scene, but refused. While undergoing medical treatment in the emergency room, Llewellyn's blood was drawn on the order of a physician for purposes of diagnosis and treatment. Lab results revealed a blood alcohol level above the legal limit. The state obtained the results pursuant to an investigative subpoena and sought to have the results entered in evidence during Llewellyn's DUI trial, citing St. v. Newill, 285 M 84, 946 P2d 134 (1997), for the holding that blood tests taken for medical diagnosis and treatment are admissible as other competent evidence. Llewellyn moved to suppress the evidence, claiming that the state could not show compliance with the required administrative procedures in the collection of the blood test for evidentiary purposes, and noting that consent had been refused under this section. The District Court granted Llewellyn's motion, distinguishing Newill, because unlike the defendant in that case, Llewellyn had exercised the statutory right to refuse to submit to a blood test for determining blood alcohol content, and concluding that admitting the evidence would allow an end run around the implied consent statutes that the Legislature could not have intended. The state sought and the Supreme Court accepted supervisory control of the evidentiary issue. Notwithstanding subsequent amendments to the implied consent statutes since Newill, the resolution of the issue was still controlled by Newill. The criteria for admissibility under this section relating to blood tests administered under the implied consent statute are inapplicable to diagnostic blood tests taken by a hospital or treating physician. There were additional competency requirements arising from the 1997 amendment to 61-8-404 that were not at issue in Newill. The court applied the foundational requirements of the 1999 versions of 61-8-404 and 61-8-405, concluding that the administration of a blood test for medical treatment purposes need not be conducted at the request of a peace officer as required by 61-8-405, because that requirement applies only to blood tests conducted pursuant to this section. Further, the court found that the administrative rule regarding the collection of blood samples for drug or alcohol analysis should be applied in Llewellyn's case to determine whether the blood test was competent evidence, but the administrative requirement that a blood sample be collected upon written request of a peace officer or officer of the court did not apply to Llewellyn's blood sample collected for medical purposes, because that requirement applies only to blood tests conducted pursuant to the implied consent statute. However, the District Court in Llewellyn's case never determined whether the medical blood test was competent evidence for purposes of admissibility under 61-8-404, so the Supreme Court remanded for a finding as to whether the medical blood test evidence was competent and admissible. State ex rel. McGrath v. District Court, 2001 MT 305, 307 M 491, 38 P3d 820 (2001).

Evidence of Reliability of Breathalyzer Irrelevant When Test Refused: Because Robertson refused to take a DUI Breathalyzer test, he lacked grounds to later challenge whether the machine in question produced reliable results; nevertheless, his refusal to take the test was admissible under 61-8-404. Missoula v. Robertson, 2000 MT 52, 298 M 419, 998 P2d 144, 57 St. Rep. 250 (2000), following St. v. Jackson, 206 M 338, 672 P2d 255, 40 St. Rep. 1698 (1983).

Hearsay Statement by Witness Not Adopted by Defendant -- Requirements for Finding Subpoenaed Witness "Unavailable": After having consumed drinks in Marysville, Widenhofer and Rothschiller were involved in a one-car accident on the Marysville Road. A car picked them up and took them to the closest business, the Silver City Bar. Because Widenhofer was injured, a highway patrol officer was called, who, upon arriving at the Silver City Bar, asked Rothschiller some questions about the accident. When he was in the patrol car with only the officer present, Rothschiller answered one of those questions by stating that Widenhofer was driving the vehicle. The officer then took both Widenhofer and Rothschiller to the hospital in Helena. After Widenhofer's injuries were cared for, the highway patrol officer continued to question Widenhofer; advised him that in the officer's opinion, alcohol was a factor in the accident; asked Widenhofer to submit to a blood-alcohol test; and read Widenhofer the implied consent form. Although Rothschiller was served with a subpoena by the Sheriff the night before a jury trial on Widenhofer's charge of DUI, Rothschiller failed to appear at trial. During the trial, the District Court allowed the highway patrol officer to repeat Rothschiller's answer, that Widenhofer was the driver of the vehicle. The Supreme Court reversed the decision of the District Court allowing the hearsay testimony. The Supreme Court held that the state's reliance on Rule 801(d)(2)(B), M.R.Ev. (Title 26, ch. 10), was misplaced because the District Court did not make an express finding that Rothschiller's statement was adopted by Widenhofer, as the District Court should have under the rationale of U.S. v. Schaff, 948 F2d 501 (9th Cir. 1991), and because the state did not present sufficient evidence that Widenhofer acquiesced in Rothschiller's statement.
The Supreme Court noted that Widenhofer could not hear the conversation between the officer and Rothschiller and had no reason to know what Rothschiller was telling the officer. For these reasons, the Supreme Court held that Rothschiller's statement as to who was driving the vehicle was not adopted by Widenhofer and that Rothschiller's statement could therefore not be allowed under this exception to the hearsay rule. Widenhofer also objected to the hearsay testimony of the highway patrol officer because it violated Widenhofer's right under the sixth amendment to the United States Constitution and under Art. II, sec. 24, Mont. Const., to confront and cross-examine a witness. The Supreme Court held that the "unavailability" exception under Rule 804(a)(5), M.R.Ev. (Title 26, ch. 10), could not be invoked because under the analysis of Ohio v. Roberts, 448 US 56 (1980), that rule requires the prosecution to demonstrate the "unavailability" of a witness before hearsay evidence of the witness's statements may be introduced. The Supreme Court held that the state's "minimal" attempt to procure Rothschiller's testimony by serving a subpoena on him the night before trial did not constitute "reasonable means" of procuring his testimony. St. v. Widenhofer, 286 M 341, 950 P2d 1383, 54 St. Rep. 1438 (1997).

Expired Manufacturer's Warranty on Breath Test Solution Used to Test Defendant: That the manufacturer's warranty on a solution used for a breath test had expired 10 months before the solution was used in testing defendant did not make the test results inadmissible. The administrative rules regulating testing clearly provide that the approval of the solution is by the Department of Justice's Division of Forensic Sciences, not by the manufacturer, and the solution had been approved by the Division as required by the rules. St. v. Woods, 285 M 124, 947 P2d 62, 54 St. Rep. 1074 (1997).

Test Results of Blood Drawn for Medical Reasons Admissible -- Implied Consent Requirements Inapplicable: When Newill was admitted to the hospital for injuries resulting from an automobile accident, a sample of her blood was drawn for medical diagnostic and treatment purposes. Tests indicated more than twice the allowable level of alcohol. During subsequent questioning, Newill admitted that she had been drinking and authorized the taking of a blood sample to determine her BAC, but a blood sample could not be obtained. Newill sought to suppress the records containing the results of the earlier blood test because the records did not comport with the foundational requirements of this section, the implied consent statute. The District Court denied the motion to suppress. On appeal, the Supreme Court held that the blood test taken at the direction of the attending physician was admissible as other competent evidence bearing upon whether Newill was intoxicated. Therefore, the District Court properly held that the blood test conducted by the hospital fell within the "other competent evidence" exclusion of 61-8-404(3). St. v. Newill, 285 M 84, 946 P2d 134, 54 St. Rep. 1055 (1997), followed in State ex rel. McGrath v. District Court, 2001 MT 305, 307 M 491, 38 P3d 820 (2001).

Blood Alcohol Test Found Voluntary: The admissibility of the results of the blood alcohol test in this case is not based on implied consent to the withdrawal of defendant's blood under this section. Instead, it is bottomed on the actual consent of the defendant which he admits. The issue turns on whether defendant's consent was voluntary or was coerced by psychological means. The court held that there was substantial evidence that defendant's consent was free and voluntary and that the lower court committed no error in denying defendant's motion to suppress the results of the blood alcohol test. St. v. Kirkaldie, 179 M 283, 587 P2d 1298, 35 St. Rep. 1532 (1978).

Attorney General's Opinions

Disclosure of Investigation Reports:

County Attorneys, law enforcement personnel, and Coroners must release reports of accident investigations, autopsies, and related tests to persons specifically listed in statutes. Public access to the results of investigations not covered by statute is left to the discretion of the public official following the guidelines set forth in this opinion and 37 A.G. Op. 107 (1978), 37 A.G. Op. 112 (1978).

Law Review Articles


Collateral References

61A C.J.S. Motor Vehicles § 1389.


Mental incapacity as justifying refusal to submit to tests for driving while intoxicated. 76 ALR 5th 597.

Driving while intoxicated: subsequent consent to sobriety test as affecting initial refusal. 28 ALR 5th 459.

Sufficiency of showing of physical inability to take tests for driving while intoxicated to justify refusal. 68 ALR 4th 776.

Snowmobile operation as DWI or DUI. 56 ALR 4th 1092.

Validity, construction, and application of statutes directly proscribing driving with blood-alcohol level in excess of established percentage. 54 ALR 4th 149.

Drunk driving: motorist's right to private sobriety test. 45 ALR 4th 11.
61-8-405. Administration of tests

(1) Only a physician or registered nurse, or other qualified person acting under the supervision and direction of a physician or registered nurse, may, at the request of a peace officer, withdraw blood for the purpose of determining any measured amount or detected presence of alcohol, drugs, or any combination of alcohol and drugs in the person. This limitation does not apply to the sampling of breath.

(2) In addition to any test administered at the direction of a peace officer, a person may request that an independent blood sample be drawn by a physician or registered nurse for the purpose of determining any measured amount or detected presence of alcohol, drugs, or any combination of alcohol and drugs in the person. The peace officer may not unreasonably impede the person's right to obtain an independent blood test. The officer may but has no duty to transport the person to a medical facility or otherwise assist the person in obtaining the test. The cost of an independent blood test is the sole responsibility of the person requesting the test. The failure or inability to obtain an independent test by a person does not preclude the admissibility in evidence of any test given at the direction of a peace officer.

(3) Upon the request of the person tested, full information concerning any test given at the direction of the peace officer must be made available to the person or the person's attorney.

(4) A physician or registered nurse, or other qualified person acting under the supervision and direction of a physician or registered nurse, does not incur any civil or criminal liability as a result of the proper administering of a blood test when requested in writing by a peace officer to administer a test.

(5) The department in cooperation with any appropriate agency shall adopt uniform rules for the giving of tests and may require certification of training to administer the tests as considered necessary.

History: En. Sec. 3, Ch. 131, L. 1971; R.C.M. 1947, 32-2142.3; amd. Sec. 4, Ch. 103, L. 1981; amd. Secs. 1, 13, Ch. 503, L. 1985; amd. Sec. 14, Ch. 378, L. 1989; amd. Sec. 5, Ch. 789, L. 1991; amd. Sec. 4, Ch. 564, L. 1993; amd. Sec. 6, Ch. 88, L. 1997.

Compiler's Comments

1997 Amendment: Chapter 88 in first sentence of (1), after "alcohol", inserted "drugs, or any combination of alcohol and drugs" and in second sentence substituted "sampling of breath" for "taking of breath or urine specimens"; at beginning of first sentence of (2) deleted "The person may, at the person's own expense, have a physician or registered nurse of the person's own choosing administer a test", after "officer" inserted "a person may request that an independent blood sample be drawn by a physician or registered nurse", after "drugs" inserted "or any combination of alcohol and drugs", and at end, after "person", deleted "at the time alleged, as shown by analysis of the person's blood, breath, or urine", inserted second and third sentences prohibiting a peace officer from unreasonably impeding a person's right to obtain an independent blood test and providing that any officer may but has no duty to transport a person to a medical facility or assist a person in obtaining a test, inserted fourth sentence providing that a person requesting an independent blood test is responsible for the cost, and in last sentence substituted "independent test" for "additional test" and substituted "any test given" for "the test or tests taken"; in (3) substituted "any test given" for "the test or tests taken"; in (4), after "person", inserted "acting"; deleted former (5) that read: "(5) If a test given under 61-8-402 or 61-8-806 is a test of urine, the person tested must be given privacy in the taking of the urine specimen that will ensure the integrity of the specimen and, at the same time, maintain the dignity of the individual involved"; and made minor changes in style.

1993 Amendment: Chapter 564 in first sentence of (2), after "alcohol", inserted "or drugs"; in second sentence of (2) and near beginning of (3), after "test", inserted "or tests"; and made minor changes in style.

1991 Amendment: In (1) substituted "any measured amount or detected presence of alcohol in the person" for "alcoholic content"; in (2) substituted "any measured amount or detected presence of alcohol in the person" for "alcoholic content"; and made minor changes in style.
alcohol in the person" for "the amount of alcohol in his blood" and before "analysis" deleted "chemical"; in (5), before "test of urine", deleted "chemical" and substituted "integrity" for "accuracy"; in (6), before "tests", deleted "blood alcohol"; and made minor changes in style.

1989 Amendment: In (5) inserted "or 61-8-806"; and made minor changes in style and grammar.

1985 Amendment: In (6) substituted reference to department of justice for references to division of motor vehicles and division of forensic sciences.

1981 Amendment: Added "or other qualified person under the supervision and direction of a physician or registered nurse" near the beginning of (1) and (4); substituted "division of forensic sciences" for "state board of health and environmental sciences" and "rules" for "standards" in (6).

Cross-References


Adoption and publication of rules, Title 2, ch. 4, part 3.

Boats -- administration of alcohol concentration tests, 23-2-535.


Licensing of physicians, Title 37, ch. 3, part 3.

Licensing of nurses, Title 37, ch. 8, part 4.

Division of Forensic Sciences, Title 44, ch. 3, part 1.

Administrative Rules

Title 23, chapter 4, subchapter 2, ARM Drug and/or alcohol analysis.

Case Notes

No Violation of Due Process Rights Upon Failure to Request Independent Blood Test: When an alleged crime involves intoxication, the accused has the right under this section to obtain, upon request, a sobriety test independent of that offered by the arresting officer. Beanblossom contended that failure to administer an independent blood test was violative of his due process rights. However, a due process violation arises only when an accused requests but is then denied an independent sobriety test. Beanblossom did not request an independent test, so no due process violation occurred. St. v. Beanblossom, 2002 MT 351, 313 M 394, 61 P3d 165 (2002).

Defendant Informed of Right to Independent Blood Test After Administration of Portable Breath Test -- No Violation of Due Process Rights: After Feldbrugge was stopped for speeding, the investigating officer noticed that Feldbrugge seemed confused, had difficulty removing his driver's license from his wallet and producing proof of registration and insurance, had bloodshot and glassy eyes and slurred speech, and was unsteady on his feet. The officer did not perform field sobriety tests, but did ask Feldbrugge to take a portable breath test (PBT). The officer read a short advisory that did not contain information regarding Feldbrugge's right to obtain an independent blood test to challenge the PBT results. Feldbrugge consented to the PBT, which he failed, and was arrested and taken to the county jail. Before being administered an Intoxilyzer breath test at the jail, Feldbrugge was read the informed consent advisory form, which included a statement regarding Feldbrugge's right to obtain an independent blood test. At trial, Feldbrugge moved to suppress the evidence on grounds that his due process rights were violated because he was not informed of the right to an independent blood test until after the PBT was administered. However, the notion that Feldbrugge had a choice between taking a PBT or obtaining an independent blood test, without penalty, was misguided. Here, it was unnecessary for the officer to inform Feldbrugge of the right to an independent blood test prior to requesting the PBT because even if Feldbrugge had been so informed, his options remained the same: consent to the PBT or refuse and have his driver's license seized. The officer was required to timely inform Feldbrugge that he could obtain an independent blood test in addition to the PBT and Intoxilyzer breath test so that Feldbrugge could gather exculpatory evidence. Informing Feldbrugge after the PBT was timely, so Feldbrugge's due process rights were not violated. Because the PBT results were admissible, Feldbrugge's arrest was supported by probable cause, and the DUI conviction was affirmed. St. v. Feldbrugge, 2002 MT 154, 310 M 368, 50 P3d 1067 (2002).

Arresting Officer's Advice Considered Frustration of Due Process Right to Independent Blood Test -- Strand Remedy for Violation of Due
Process Rights Overruled: Minkoff was arrested for DUI and informed of his right to an independent blood test. Minkoff asked the arresting officer whether he should get a blood test, and the officer initially replied that he could not advise Minkoff, but that the test would only be given at Minkoff's expense. Minkoff then asked whether there was any difference between the blood test and the breath test, and the officer repeatedly stated that the blood test would be more exact and higher than the breath test. Minkoff then took a breath test, which he failed, but did not request a blood test. After being convicted, Minkoff appealed on grounds that his right to an independent blood test was frustrated by the arresting officer's response to the inquiry about whether to get a blood test. The District Court had relied on St. v. Sidmore, 286 M 218, 951 P2d 558 (1997), in denying Minkoff's motion to dismiss. Sidmore provides that two criteria must be met to support an allegation of denial of due process rights regarding the right to an independent test: (1) the accused must timely claim the right to an independent blood test; and (2) a law enforcement officer must unreasonably impede the defendant's right to obtain an independent blood test. Here, given the immediacy of the officer's advice, the period within which Minkoff could timely request the test under the first Sidmore criteria had not passed, and to conclude otherwise would permit frustration of a person's due process right to an independent test in advance of the person's reasonable opportunity to request the test. Then, to determine whether the officer unreasonably frustrated Minkoff's right to obtain the blood test, the Supreme Court applied Lau v. St., 896 P2d 825 (Alaska 1995). Under Lau, a government officer having custody of an arrested driver cannot attempt to dissuade the driver from exercising the right to an independent blood test. Here, the officer's repeated statements, albeit well-intentioned, that a blood test would show a higher blood alcohol level, were affirmative acts that would frustrate, if not obliterate, the intention of any rational arrestee to obtain an independent blood test. Regarding the proper remedy for such a due process violation, the Supreme Court previously held in St. v. Strand, 286 M 122, 951 P2d 552 (1997), that suppression of the breath test was an appropriate remedy on the basis that if the state frustrated the right to an independent test, it could not then be allowed to use its own scientific evidence of intoxication against the defendant. On further consideration, the Supreme Court held that the Strand remedy was manifestly incorrect and overruled Strand in that regard, holding that dismissal rather than suppression of the breath test is the appropriate remedy when the right to an independent blood test is frustrated. St. v. Minkoff, 2002 MT 29, 308 M 248, 42 P3d 223 (2002).

Blood Test Results From Emergency Medical Treatment Admissible as DUI Evidence Notwithstanding Lack of Consent to Blood Test: Llewellyn was involved in an automobile accident, sustaining significant injuries. Llewellyn was asked to submit to a blood test at the accident scene, but refused. While undergoing medical treatment in the emergency room, Llewellyn's blood was drawn on the order of a physician for purposes of diagnosis and treatment. Lab results revealed a blood alcohol level above the legal limit. The State obtained the results pursuant to an investigative subpoena and sought to have the results entered in evidence during Llewellyn's DUI trial, citing St. v. Newill, 285 M 84, 946 P2d 134 (1997), for the holding that blood tests taken for medical diagnosis and treatment are admissible as other competent evidence. Llewellyn moved to suppress the evidence, claiming that the state could not show compliance with the required administrative procedures in the collection of the blood test for evidentiary purposes, and noting that consent had been refused under 61-8-402. The District Court granted Llewellyn's motion, distinguishing Newill, because unlike the defendant in that case, Llewellyn had exercised the statutory right to refuse to submit to a blood test for determining blood alcohol content, and concluding that admitting the evidence would allow an end run around the implied consent statutes that the Legislature could not have intended. The state sought and the Supreme Court accepted supervisory control of the evidentiary issue. Notwithstanding subsequent amendments to the implied consent statutes since Newill, the resolution of the issue was still controlled by Newill. The criteria for admissibility under 61-8-402 relating to blood tests administered under the implied consent statute are inapplicable to diagnostic blood tests taken by a hospital or treating physician. There were additional competency requirements arising from the 1997 amendment to 61-8-404 that were not at issue in Newill. The court applied the foundational requirements of the 1999 versions of 61-8-404 and this section, concluding that the administration of a blood test for medical treatment purposes need not be conducted at the request of a peace officer as required by this section, because that requirement applies only to blood tests conducted pursuant to 61-8-402. Further, the court found that the administrative rule regarding the collection of blood samples for drug or alcohol analysis should be applied in Llewellyn's case to determine whether the blood test was competent evidence, but the
administrative requirement that a blood sample be collected upon written request of a peace officer or officer of the court did not apply to Llewellyn's blood sample collected for medical purposes, because that requirement applies only to blood tests conducted pursuant to the implied consent statute. However, the District Court in Llewellyn's case never determined whether the medical blood test was competent evidence for purposes of admissibility under 61-8-404, so the Supreme Court remanded for a finding as to whether the medical blood test evidence was competent and admissible. State ex rel. McGrath v. District Court, 2001 MT 305, 307 M 491, 38 P3d 820 (2001).

**Allegation of Misinformation in Implied Consent Advisory Form as Applied to Nonresident -- Motion to Suppress Results of Breath Test Properly Denied:** Ferguson pleaded guilty to driving under the influence of alcohol and driving the wrong way on a one-way street, but reserved his right to appeal the denial of his motion to suppress the evidence of his breath test. On appeal, Ferguson argued that the test results should have been suppressed because the implied consent advisory form misstated the law as it applied to him as a resident of Iowa and that he was thus unlawfully coerced into taking the breath test without having all the correct and relevant information upon which to make an informed decision. The Supreme Court affirmed the denial of the motion to suppress. The purposes of implied consent advisory forms are to put an apparently intoxicated driver on notice of the potentially serious consequences of refusing a blood alcohol test and to alert the driver of the due process protections germane to independent testing and posttesting hearings. Those purposes were accomplished here. Given that Ferguson's right to operate a motor vehicle faced suspension in both states because he refused to take the breath test and in light of the fact that he was told that his license would be returned to Iowa if he refused to take the test, his argument that he was misled or unlawfully coerced was unpersuasive. Missoula v. Ferguson, 2001 MT 69, 305 M 36, 22 P3d 198 (2001), following St. v. Simmons, 2000 MT 329, 303 M 60, 15 P3d 408 (2000).

**Laying Proper Foundation for Breath Test Information:** Incashola was granted a motion in limine, effectively suppressing breath test information, on grounds that the state had not laid a proper foundation for admission of the test result by performing a proper field certification on the Intoxilyzer following the test, implied as required under ARM 23.4.213(1)(i). The state had opposed the motion, arguing that the field certification performed 4 days before Incashola's arrest fell within the 7-day test validity provided for in ARM 23.4.213(1)(i), thus establishing the proper foundation for admission of the test results. The Supreme Court noted that a defendant charged with driving under the influence is entitled to the procedural safeguards contained in the administrative rule and that if a proper foundation is not laid through state compliance with the safeguards, the results of the breath test analysis are inadmissible. ARM 23.4.213(1)(i) is not a foundational requirement for the admissibility of breath test results. Rather, the trial court may use the inference created by ARM 23.4.213(1)(i) to determine whether the testing instrument was in proper working order. In other words, if evidence establishes that proper field certifications were performed both before and after the breath test at issue, the trial court may infer that the test instrument was in working order. ARM 23.4.213(1)(i) is a foundational requirement for admissibility of breath test results because a proper field certification performed within 7 days of the test at issue constitutes an adequate foundation for admissibility. The proper field certification having been timely made and an adequate foundation laid, the trial court abused its discretion in granting Incashola's motion in limine. The case was reversed and remanded, with a reminder that both parties were still free to offer other evidence at trial with regard to whether the instrument was in proper working order on the day of Incashola's breath test. St. v. Incashola, 1998 MT 184, 289 M 399, 961 P2d 745, 55 St. Rep. 742 (1998).

**Discrepancy Between Time of Report and Time Recorded on Intoxilyzer:** The arresting officer adjusted the time recorded on an Intoxilyzer 5000 printout to correspond to the highway patrol time that was used when documenting defendant's arrest and processing. The corrected time, indicating a 17-minute observation period prior to administration of the test, was used to determine whether the instrument was in working order. Armed with the 17-minute observation period, the trial court would have granted Incashola's motion to suppress the test results. The Supreme Court clarified that Swanson Rule (ARM 23.4.212), which requires a 15-minute observation period, was still applicable and properly accepted as competent evidence of compliance with ARM 23.4.212, which requires a 15-minute observation period. St. v. Fenton, 1998 MT 99, 288 M 415, 958 P2d 68, 55 St. Rep. 389 (1998).

**When Right to Obtain Independent Blood Test Unreasonably Impeded -- No Due Process Violation -- Swanson Rule Clarified:** One accused of a crime involving intoxication is entitled to obtain an independent blood test only when: (1) the defendant has timely claimed the right to an independent blood
test; and (2) a law enforcement officer has unreasonably impeded the defendant's right to obtain an independent blood test. Both criteria must be satisfied in order to support an allegation of violation of a defendant's due process rights. The rule does not apply either if the defendant fails to timely request the independent blood test or if the independent blood test is unavailable through no unreasonable acts of law enforcement. In the present case, Sidmore's due process rights were not violated because the unavailability of an independent blood test was not caused by an unreasonable action of law enforcement but rather by Sidmore's own failure to act after requesting and being given the opportunity to arrange an independent blood test. 


**Breathalyzer Tested Twelve Minutes After Mandated Seven-Day Period Between Tests -- Breath Test Admissible:** ARM 23.4.213 requires Breathalyzers to be tested and certified for accuracy every 7 days. The Breathalyzer used on the defendant on August 23 had been tested that day at 8:59 a.m. and on August 16 at 8:47 a.m., a time difference of 7 days and 12 minutes. Section 1-1-305 provides that fractions of a day are disregarded in computations that include more than a day and involve no questions of priority. For most purposes, the law regards a day as an indivisible unit. Neither the administrative rule nor other law supported defendant's argument that the test results were inadmissible because more than 7 days had passed between the two tests. St. v. Fitzgerald, 283 M 162, 940 P2d 108, 54 St. Rep. 545 (1997).

**Compliance With Administrative Rules of Montana -- Criminal Actions:** Prior to administering the Intoxilyzer 5000 test to the defendant, the calibration checks read 0.060 and 0.062 for a simulator solution that was supposed to have had a known alcohol concentration of 0.10. The Administrative Rules of Montana require a calibration check to fall within a plus or minus one-tenth range of the known alcohol concentration of the reference solution to guarantee the instrument's accuracy prior to administering the test. The Supreme Court held that the evidence showed that the low calibration readings were not indicative of a faulty instrument but only of a gradually diminished alcohol content in the simulator solution. The court further held that the District Court did not err in holding that the test was administered in substantial compliance with the Administrative Rules of Montana. O'Brian v. St., 236 M 227, 770 P2d 507, 46 St. Rep. 316 (1989), followed in St. v. Carter, 285 M 449, 948 P2d 1173, 54 St. Rep. 1235 (1997).

**Admissibility of "HGN" Test:** The Supreme Court adopted the position of several out-of-state courts in holding that results of the horizontal gaze nystagmus (HGN) test are admissible in Montana as one method of indicating impairment. St. v. Clark, 234 M 222, 762 P2d 853, 45 St. Rep. 1859 (1988).

**Retroactive Application of Swanson Rule:** Following arrest on a charge of driving under the influence of alcohol or drugs, defendant refused to take a breath test requested by the arresting officer and demanded to make a telephone call to an attorney and to obtain a blood test. Police told defendant that if he did not take the breath test, neither the telephone call nor the blood test would be permitted. Police then placed defendant in a holding cell, denying him the call and blood test for 10 hours. Upon conviction, defendant appealed, alleging police refusal denied him due process of law. Applying the Swanson rule, 222 M 357, 722 P2d 1155, 43 St. Rep. 1329 (1986), which established the right to obtain an independent blood test when accused of crime involving intoxication, the court reversed the conviction, ruling that Swanson should be retroactively applied. The 10-hour delay constituted an interference with defendant's right to obtain exculpatory evidence, which is the type of due process denial against which Swanson was designed to protect. St. v. Peterson, 227 M 418, 739 P2d 958, 44 St. Rep. 1198 (1987).

**Careless Handling of Blood Sample -- Deprivation of Due Process and Fair Trial:** Defendant was taken to a hospital where a blood sample was drawn; then he was transported back to the Sheriff's office where he was booked and his personal property, including the blood sample, was taken from him. The blood sample was left on the counter in the dispatch room rather than being refrigerated and was not given to defendant upon his release. The Supreme Court held that once the sample was taken from defendant, the authorities had a duty to properly care for it. Since this duty was not performed, the careless handling of the sample deprived defendant of his due process right to gather possible exculpatory evidence, precluding a fair trial. St. v. Swanson, 222 M 357, 722 P2d 1155, 43 St. Rep. 1329 (1986), distinguished in St. v. Heth, 230 M 418, 739 P2d 958, 44 St. Rep. 1198 (1987).
Right to Independent Blood Test in Crime Involving Intoxication: The state interpreted 61-8-405 to mean that the right to an independent blood test arises only after an accused takes a test designated by the arresting officer. The Supreme Court, citing an Arizona Appellate Court interpretation of an identical statute, found that such an interpretation would result in an unconstitutional restraint on the right of a criminal accused to attempt to obtain independent evidence of his innocence and deprive him of due process of law (Smith v. Cada, 562 P2d 390 (Ariz. App. 1977)). Therefore, it was held that a person accused of a crime involving intoxication has a right to obtain an independent blood test to establish his sobriety regardless of whether he submits to a police designated test under 61-8-402. St. v. Swanson, 222 M 357, 722 P2d 1155, 43 St. Rep. 1329 (1986), distinguished in Walker v. St., 229 M 331, 746 P2d 624, 44 St. Rep. 2008 (1987), on grounds that defendant Walker was subject to civil penalty under 61-8-402, not criminal penalty under this section.

Foundation Required for Admissibility of Blood Test Results: Defendant on a charge of driving under the influence of alcohol or drugs in violation of 61-8-401 is entitled to the procedural safeguards of the Administrative Rules of Montana. To admit evidence of blood alcohol content and a test report, the state must lay a foundation pursuant to 61-8-404 which incorporates ARM 23.3.931. The laboratory analysis must be done in a laboratory qualified under the rules of the Department of Justice. The report must be prepared in accordance with the rules of the Department. If a blood sample is taken, the person withdrawing the blood must be demonstrably qualified to do so, St. v. McDonald, 215 M 340, 697 P2d 1328, 42 St. Rep. 414 (1985), cited in St. v. Decker, 251 M 339, 828 P2d 1342, 48 St. Rep. 1046 (1991).

Compliance With Administrative Rules: Although a criminal defendant is entitled to the safeguards of an administrative rule setting out blood testing procedures and implementing the statute providing for blood alcohol tests of drivers arrested for driving while under the influence before the presumption of being under the influence can arise from a certain blood alcohol level, it does not follow that the same procedural safeguards must be applied when blood test results are used in a civil proceeding, especially when the statutory presumption used in criminal cases is not relied upon. Therefore, where testimony in civil action established that witnesses for parties introducing test results followed good practice in the testing field, it was not error to fail, on a foundation for admitting test results, to prove compliance with the administrative rule. McAlpine v. Midland Elec. Co., 194 M 154, 634 P2d 1166, 38 St. Rep. 1577 (1981).

Attorney General's Opinions

Disclosure of Investigation Reports:


Law Review Articles


Collateral References

61A C.J.S. Motor Vehicles § § 1407, 1411.


Drunk driving: motorist's right to private sobriety test. 45 ALR 4th 11.

MCA 61-8-405, MT ST 61-8-405

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
Subject to additional definitions contained in the subsequent chapters that are applicable to specific chapters, parts, or sections and unless the context otherwise requires, in chapters 1 through 5, the following definitions apply:

(1) "Agent" includes an attorney-in-fact under a durable or nondurable power of attorney, an individual authorized to make decisions concerning another's health care, and an individual authorized to make decisions for another under a natural death act.

(2) "Application" means a written request to the clerk for an order of informal probate or appointment under chapter 3, part 2.

(3) "Beneficiary", as it relates to:

(a) a trust beneficiary, includes a person who has any present or future interest, vested or contingent, and also includes the owner of an interest by assignment or other transfer;

(b) a charitable trust, includes any person entitled to enforce the trust;

(c) a beneficiary of a beneficiary designation, refers to a beneficiary of:

(i) an account with POD designation or a security registered in beneficiary form (TOD); or

(ii) any other nonprobate transfer at death; and

(d) a beneficiary designated in a governing instrument, includes a grantee of a deed, a devisee, a trust beneficiary, a beneficiary of a beneficiary designation, a donee, and a person in whose favor a power of attorney or a power held in any individual, fiduciary, or representative capacity is exercised.

(4) "Beneficiary designation" refers to a governing instrument naming a beneficiary of:

(a) an account with POD designation or a security registered in beneficiary form (TOD); or

(b) any other nonprobate transfer at death.

(5) "Child" includes an individual entitled to take as a child under chapters 1 through 5 by intestate succession from the parent whose relationship is involved and excludes a person who is only a stepchild, a foster child, a grandchild, or any more remote descendant.

(6) (a) "Claims", in respect to estates of decedents and protected persons, includes liabilities of the decedent or protected person, whether arising in contract, in tort, or otherwise, and liabilities of the estate that arise at or after the death of the decedent or after the appointment of a conservator, including funeral expenses and expenses of administration.

(b) The term does not include estate taxes or demands or disputes regarding title of a decedent or protected person to specific assets alleged to be included in the estate.

(7) "Clerk" or "clerk of court" means the clerk of the district court.

(8) "Conservator" means a person who is appointed by a court to manage the estate of a protected person.

(9) "Court" means the district court in this state having jurisdiction in matters relating to the affairs of decedents.

(10) "Descendant" of an individual means all of the individual's descendants of all generations, with the relationship of parent and child at each generation being determined by the definition of child and parent contained in this section.

(11) "Devise" when used as a noun means a testamentary disposition of real or personal property and when used as a verb means to dispose of real or personal property by will.

(12) "Devisee" means a person designated in a will to receive a devise. For purposes of chapter 3, in the case of a devisee to an existing trust or trustee or to a trustee or trust described by will, the trust or trustee is the devisee and the beneficiaries are not devisees.

(13) "Disability" means cause for a protective
order as described by 72-5-409.

(14) "Distributee" means any person who has received property of a decedent from the decedent's personal representative other than as a creditor or purchaser. A testamentary trustee is a distributee only to the extent of distributed assets or increment to distributed assets remaining in the trustee's hands. A beneficiary of a testamentary trust to whom the trustee has distributed property received from a personal representative is a distributee of the personal representative. For purposes of this provision, "testamentary trustee" includes a trustee to whom assets are transferred by will, to the extent of the devised assets.

(15) "Estate" includes the property of the decedent, trust, or other person whose affairs are subject to chapters 1 through 5 as originally constituted and as it exists from time to time during administration.

(16) "Exempt property" means that property of a decedent's estate that is described in 72-2-413.

(17) "Fiduciary" includes a personal representative, guardian, conservator, and trustee.

(18) "Foreign personal representative" means a personal representative appointed by another jurisdiction.

(19) "Formal proceedings" means proceedings conducted before a judge with notice to interested persons.

(20) "Governing instrument" means a deed; will; trust; insurance or annuity policy; account with POD designation; security registered in beneficiary form (TOD); pension, profit-sharing, retirement, or similar benefit plan; instrument creating or exercising a power of appointment or a power of attorney; or dispositive, appointive, or nominative instrument of any similar type.

(21) "Guardian" means a person who has qualified as a guardian of a minor or incapacitated person pursuant to testamentary or court appointment but excludes one who is merely a guardian ad litem.

(22) "Heirs", except as controlled by 72-2-721, means persons, including the surviving spouse and the state, who are entitled under the statutes of intestate succession to the property of a decedent.

(23) "Incapacitated person" has the meaning provided in 72-5-101.

(24) "Informal proceedings" means proceedings conducted without notice to interested persons by the clerk of court for probate of a will or appointment of a personal representative.

(25) "Interested person" includes heirs, devisees, children, spouses, creditors, beneficiaries, and any others having a property right in or claim against a trust estate or the estate of a decedent, ward, or protected person. The term also includes persons having priority for appointment as personal representative and other fiduciaries representing interested persons. The meaning as it relates to particular persons may vary from time to time and must be determined according to the particular purposes of and matter involved in any proceeding.

(26) "Issue" of a person means a descendant.

(27) "Joint tenants with the right of survivorship" includes co-owners of property held under circumstances that entitle one or more to the whole of the property on the death of the other or others but excludes forms of co-ownership registration in which the underlying ownership of each party is in proportion to that party's contribution.

(28) "Lease" includes an oil, gas, coal, or other mineral lease.

(29) "Letters" includes letters testamentary, letters of guardianship, letters of administration, and letters of conservatorship.

(30) "Minor" means a person who is under 18 years of age.

(31) "Mortgage" means any conveyance, agreement, or arrangement in which property is used as security.

(32) "Nonresident decedent" means a decedent who was domiciled in another jurisdiction at the time of death.

(33) "Organization" means a corporation, business trust, estate, trust, partnership, joint venture, association, government or governmental subdivision or agency, or any other legal or commercial entity.

(34) "Parent" includes any person entitled to
take, or who would be entitled to take if the child died without a will, as a parent under chapters 1 through 5 by intestate succession from the child whose relationship is in question and excludes any person who is only a stepparent, foster parent, or grandparent.

(35) "Payor" means a trustee, insurer, business entity, employer, government, governmental agency or subdivision, or any other person authorized or obligated by law or a governing instrument to make payments.

(36) "Person" means an individual, a corporation, an organization, or other legal entity.

(37) "Personal representative" includes executor, administrator, successor personal representative, special administrator, and persons who perform substantially the same function under the law governing their status. "General personal representative" excludes special administrator.

(38) "Petition" means a written request to the court for an order after notice.

(39) "Proceeding" includes action at law and suit in equity.

(40) "Property" includes both real and personal property or any interest in that property and means anything that may be the subject of ownership.

(41) "Protected person" has the meaning provided in 72-5-101.

(42) "Protective proceeding" has the meaning provided in 72-5-101.

(43) "Security" includes any note; stock; treasury stock; bond; debenture; evidence of indebtedness; certificate of interest or participation in an oil, gas, or mining title or lease or in payments out of production under such a title or lease; collateral trust certificate; transferable share; voting trust certificate; in general, any interest or instrument commonly known as a security; any certificate of interest or participation; or any temporary or interim certificate, receipt, or certificate of deposit for or any warrant or right to subscribe to or purchase any of the foregoing.

(44) "Settlement", in reference to a decedent's estate, includes the full process of administration, distribution, and closing.

(45) "Special administrator" means a personal representative as described by chapter 3, part 7.

(46) "State" means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or any territory or insular possession subject to the jurisdiction of the United States.

(47) "Successor personal representative" means a personal representative, other than a special administrator, who is appointed to succeed a previously appointed personal representative.

(48) "Successors" means persons, other than creditors, who are entitled to property of a decedent under the decedent's will or chapters 1 through 5.

(49) "Supervised administration" refers to the proceedings described in chapter 3, part 4.

(50) "Survive" means that an individual has neither predeceased an event, including the death of another individual, nor is considered to have predeceased an event under 72-2-114 or 72-2-712. The term includes its derivatives, such as "survives", "survived", "survivor", and "surviving".

(51) "Testacy proceeding" means a proceeding to establish a will or determine intestacy.

(52) "Testator" includes an individual of either sex.

(53) "Trust" includes an express trust, private or charitable, with additions to the trust, wherever and however created. The term also includes a trust created or determined by judgment or decree under which the trust is to be administered in the manner of an express trust. The term excludes other constructive trusts and excludes resulting trusts; conservatorships; personal representatives; trust accounts as defined in 72-6-111 and Title 72, chapter 6, parts 2 and 3; custodial arrangements pursuant to chapter 26; business trusts providing for certificates to be issued to beneficiaries; common trust funds; voting trusts; security arrangements; liquidation trusts; trusts for the primary purpose of paying debts, dividends, interest, salaries, wages, profits, pensions, or employee benefits of any kind; and any arrangement under which a person is nominee or escrowee for another.

(54) "Trustee" includes an original, additional, or successor trustee, whether or not appointed or confirmed by court.
(55) "Ward" means an individual described in 72-5-101.

(56) "Will" includes codicil and any testamentary instrument that merely appoints an executor, revokes or revises another will, nominates a guardian, or expressly excludes or limits the right of an individual or class to succeed to property of the decedent passing by intestate succession.

History: En. 91A-1-201 by Sec. 1, Ch. 365, L. 1974; R.C.M. 1947, 91A-1-201; amd. Sec. 3, Ch. 494, L. 1993; amd. Sec. 2, Ch. 592, L. 1995; amd. Sec. 16, Ch. 9, Sp. L. May 2000; amd. Sec. 77, Ch. 130, L. 2005.

NOTES, REFERENCES, AND ANNOTATIONS

Official Comments

Special definitions for Articles V and VI are contained in Sections 5-103 [72-5-101], 6-201 [72-6-201], and 6-301 [72-6-301]. Except as controlled by special definitions applicable to these particular Articles, or applicable to particular sections, the definitions in Section 1-201 [72-1-103] apply to the entire Code.

Compiler's Comments

2005 Amendment: Chapter 130 in definition of devisee after "trustee" substituted "or" for "on". Amendment effective October 1, 2005.

2000 Amendment by Referendum: Chapter 9 in definition of claims in (b) after "estate" deleted "or inheritance"; and made minor changes in style. Amendment effective November 7, 2000.

Applicability: Section 38, Ch. 9, Sp. L. May 2000, provided: "This act applies to deaths occurring after December 31, 2000."

1995 Amendment: Chapter 592 in definition of beneficiary, in (c)(i) at beginning, deleted "an insurance or annuity policy", deleted former (c)(ii) that read: "(ii) a pension, profit-sharing, retirement, or similar benefit plan", and in (d), after "donee", deleted "appointee, or taker in default of a power of appointment"; in definition of beneficiary designation, at beginning of (a), deleted "an insurance or annuity policy" and deleted former (b) that read: "(b) a pension, profit-sharing, retirement, or similar benefit plan"; and in definition of survive, at beginning, deleted "except for purposes of Title 72, chapter 6, part 3".

1993 Amendment: Chapter 494 inserted definitions of agent, beneficiary designation, descendant, governing instrument, joint tenants with right of survivorship, payor, survive, and testator; in introductory clause, after "parts", inserted "or sections" and substituted "chapters 1 through 5" for "this code"; in definition of beneficiary inserted (c) concerning a beneficiary of a beneficiary designation and inserted (d) concerning a beneficiary designated in a governing instrument; in definition of child, after "under", substituted "chapters 1 through 5" for "this code" and inserted last clause excluding certain descendants; in definition of court substituted "district court in this state" for "court" and deleted last sentence that read: "This court in this state is known as district court"; in definition of devisee, at beginning of second sentence, inserted "For purposes of chapter 3"; in definition of estate substituted "chapters 1 through 5" for "this code"; in definition of foreign personal representative substituted "appointed by" for "of"; in definition of heirs, near beginning, inserted exception clause and after "spouse" inserted "and the state"; in definition of interested person, at end of first sentence, deleted "which may be affected by the proceeding"; in definition of issue substituted "a descendant as defined in subsection (10)" for "all his lineal descendants of all generations, with the relationship of parent and child at each generation being determined by the definitions of child and parent contained in this code"; in definition of organization, after "partnership", inserted "joint venture", after "association" deleted "two or more persons having a joint or common interest", and at end, before "entity", inserted "or commercial"; in definition of parent substituted "chapters 1 through 5" for "this code" and at end inserted clause excluding certain individuals; in definition of state, before "possession", inserted "insular" and after "subject to the" substituted "jurisdiction" for "legislative authority"; in definition of successors, at end, substituted "chapters 1 through 5" for "this code"; in definition of trust, in third sentence, inserted reference to trust accounts; in definition of will, at end, inserted "nominates a guardian, or expressly excludes or limits the right of an individual or class to succeed to property of the decedent passing by intestate succession"; and made minor changes in style.

Saving Clause: Section 136, Ch. 494, L. 1993.
was a saving clause.

**UPC Section:** The corresponding section in the Uniform Probate Code as adopted by the National Conference of Commissioners on Uniform State Laws is section 1-101.

**Changes From Uniform Act:**

The Montana enactment substituted the definition of "Clerk" or "clerk of court" and made minor changes in phraseology.

**Case Notes**

**Grandparents Properly Included as Parties to Future Matters Involving Grandchildren's Conservatorships:** The grandparents were court-appointed guardians for their three grandchildren. Following a train derailment and chlorine spill, the grandparents negotiated settlements with two railroads for personal injuries and damages to the children and then sought appointment of a guardian ad litem to manage and protect the settlements. The children's mother did not object to the settlement amounts but opposed a proposed plan for administering the trust and asked to be substituted for the grandparents as petitioner. Just prior to a hearing approving the settlements, the grandparents' guardianships were dissolved and the children began living with their mother. The settlements were approved, and the District Court appointed an attorney as conservator of the estates. The court also approved, and the District Court appointed an attorney as conservator of the estates. The court also approved, and the District Court appointed an attorney as conservator of the estates.

**Right of Minor Children to Bring Wrongful Death Action Though Spouse Survives:** The issue of a decedent who is survived by his spouse may maintain an action for damages under 27-1-513, even though the Uniform Probate Code (UPC) now defines "heirs" as those who are entitled to the property of the decedent under intestate succession and, under the intestacy statute, are "interested persons", and had no standing to contest fees or to argue reasonableness of the fees of the personal representative or the estate's attorneys. An annuity contract did not constitute insurance proceeds. In re Estate of Miles v. Miles, 2000 MT 41, 298 M 312, 994 P2d 1139, 57 St. Rep. 191 (2000).

**Conservator as Interested Person:** A conservator is an "interested person", under the definition in 72-1-103, and has the right to oppose or contest the probate of a will. In re Tennant, 220 M 78, 714 P2d 122, 43 St. Rep. 189 (1986).

**Proper "Heir" to Bring Wrongful Death Action - Daughter Survived by Mother and Sister:** When decedent was killed in an auto accident, her only surviving relative of any degree of kinship mentioned in the intestate succession statute were her mother and a sister, who filed a joint petition for a declaratory judgment as to who could maintain an action for decedent's wrongful death. The District Court correctly ruled that the mother was the sole heir for purposes of bringing the action. The court applied the intestate succession statutory definition of "heirs" in effect at the time the wrongful death act was amended to allow only the "heirs and personal representatives" of the decedent to recover. "Heirs" means those who take upon decedent's death under the intestacy statute. In re Norwest Capital Management & Trust Co., 215 M 399, 697 P2d 930, 42 St. Rep. 493 (1985).

**Property Right in or Claim Against Estate Required to Be Considered Interested Person:** When claimant's only claim against the estate was to the extent to which they were entitled to one-half of any insurance proceeds payable to the estate and there were no insurance proceeds, the claimants had no right in or claim against the estate, were not
probate proceedings under 72-3-305, which indicates that the Legislature intended named devisees to be parties to formal probate proceedings, and as such they are entitled to notice of the entry of an order in the proceeding as required by Rule 77(d), M.R.Civ.P.


Law Review Articles


Collateral References

31 Am. Jur. 2d Executors and Administrators § § 4, 8, 10; 79 Am. Jur. 2d Wills § § 737, 739.

MCA 72-1-103, MT ST 72-1-103

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
Guardianship for an incapacitated person may be used only as is necessary to promote and protect the well-being of the person. The guardianship must be designed to encourage the development of maximum self-reliance and independence in the person and may be ordered only to the extent that the person's actual mental and physical limitations require it. An incapacitated person for whom a guardian has been appointed is not presumed to be incompetent and retains all legal and civil rights except those that have been expressly limited by court order or have been specifically granted to the guardian by the court.

History: En. Sec. 2, Ch. 344, L. 1981.

Case Notes

Guardian Entitled to Award of Attorney Fees for Appointment as Guardian -- Award in Nonadversarial Proceeding Held Not to Violate General Rule for Award of Attorney Fees -- Award Approved Though Not Requested in Original Petition for Appointment: Appellant contested the payment of $30,000 in legal fees from the estate of a ward to the attorney representing the guardian appointed by the District Court, arguing that the general rule is that attorney fees are not payable to a prevailing party without special statutory provisions to the contrary and that the original petition for appointment of the guardian did not include a request for payment of attorney fees. The Supreme Court affirmed the order of the District Court awarding the fees. The Supreme Court pointed out, citing opinions from other states, that the general rule regarding payment of fees applies to adversarial proceedings and that the appointment of a guardian is not an adversarial proceeding but is a proceeding in rem to promote the bests interests of the ward and to protect the ward's estate. The Supreme Court also held that under Rule 54(c), M.R.Civ.P. (Title 25, ch. 20), the District Court may grant relief to which a party is entitled regardless of whether the party has specifically requested the relief granted. The Supreme Court noted that the payment of the guardian's legal fees by the estate of the ward is relief to which the guardian would be entitled under 72-5-428(1) if the petition for appointment was brought in good faith and the appointment was in the bests interests of the ward. In re Estate of Bayers, 1999 MT 154, 295 M 89, 983 P2d 339, 56 St. Rep. 607 (1999).

Limited Guardianship Appropriate to Encourage Self-Reliance and Independence: West sought a change of guardianship in order to allow him to grant gifts and to establish a program of estate tax planning. The District Court terminated the general guardianship and established a limited guardianship but denied a joint petition to substitute the conservatorship with a trust. West contended error because he no longer met the definition of incapacitated person under 72-5-101 and because 72-5-316 does not permit a limited guardianship when a protected person can meet the essential requirements for physical health and safety. A guardianship was appropriate in this case because West's physical capabilities were not likely to improve and some mental impairment remained. Under this section, a limited guardianship was permitted because it enumerated only certain decisions regarding financial affairs that could be made for West in the event that he was unable to do so, encouraging the development of maximum self-reliance and independence while promoting and protecting his well-being. In re Estate of West, 269 M 83, 887 P2d 222, 51 St. Rep. 1409 (1994).

No Showing of Incapacitation: Neither Ole nor Gladys Swandal, an elderly couple whose health was failing, was an "incapacitated person" within the meaning of 72-5-101 and 72-5-306. These statutes clearly require a showing of both physical and mental impairment, and no evidence was presented that showed that the Swandals were mentally infirm. The fact that other people might run the Swandals' ranch...

MCA 72-5-306, MT ST 72-5-306

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
72-5-320. Purposes for establishment of limited guardianship

A petition seeking the establishment of a limited guardianship shall specify the particular powers that the limited guardian is proposed to exercise and the particular areas of protection and assistance required. The purposes for which a limited guardian may be appointed include:

(1) to care for and maintain the alleged incapacitated person;

(2) to assert and protect the rights and best interests of the alleged incapacitated person;

(3) to provide timely and informed consent to necessary medical procedures and procedures implemented in connection with habilitation and training programs;

(4) to assist in the acquisition of necessary training, habilitation, and education for the incapacitated person;

(5) to exercise any other powers, duties, or limitations in regard to the care of the incapacitated person or the management of his property that the petition shall explicitly specify and which may be no greater than the powers a full guardian can exercise.

History: En. Sec. 7, Ch. 344, L. 1981.
72-5-321. Powers and duties of guardian of incapacitated person

(1) The powers and duties of a limited guardian are those specified in the order appointing the guardian. The limited guardian is required to report the condition of the incapacitated person and of the estate that has been subject to the guardian's possession and control, as required by the court or by court rule.

(2) A full guardian of an incapacitated person has the same powers, rights, and duties respecting the ward that a parent has respecting an unemancipated minor child, except that a guardian is not liable to third persons for acts of the ward solely by reason of the parental relationship. In particular and without qualifying the foregoing, a full guardian has the following powers and duties, except as limited by order of the court:

(a) To the extent that it is consistent with the terms of any order by a court of competent jurisdiction relating to detention or commitment of the ward, the full guardian is entitled to custody of the person of the ward and may establish the ward's place of residence within or outside of this state.

(b) If entitled to custody of the ward, the full guardian shall make provision for the care, comfort, and maintenance of the ward and whenever appropriate arrange for the ward's training and education. Without regard to custodial rights of the ward's person, the full guardian shall take reasonable care of the ward's clothing, furniture, vehicles, and other personal effects and commence protective proceedings if other property of the ward is in need of protection.

(c) A full guardian may give any consents or approvals that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment, or service. This subsection (2)(c) does not authorize a full guardian to consent to the withholding or withdrawal of life-sustaining treatment or to a do not resuscitate order if the full guardian does not have authority to consent pursuant to the Montana Rights of the Terminally Ill Act, Title 50, chapter 9, or to the do not resuscitate provisions of Title 50, chapter 10. A full guardian may petition the court for authority to consent to the withholding or withdrawal of life-sustaining treatment or to a do not resuscitate order. The court may not grant that authority if it conflicts with the ward's wishes to the extent that those wishes can be determined. To determine the ward's wishes, the court shall determine by a preponderance of evidence if the ward's substituted judgment, as applied to the ward's current circumstances, conflicts with the withholding or withdrawal of life-sustaining treatment or a do not resuscitate order.

(d) If a conservator for the estate of the ward has not been appointed, a full guardian may:

(i) institute proceedings to compel any person under a duty to support the ward or to pay sums for the welfare of the ward to perform that person's duty;

(ii) receive money and tangible property deliverable to the ward and apply the money and property for support, care, and education of the ward. However, the full guardian may not use funds from the ward's estate for room and board that the full guardian, the full guardian's spouse, parent, or child has furnished the ward unless a charge for the service is approved by order of the court made upon notice to at least one of the next of kin of the incompetent ward, if notice is possible. The full guardian must exercise care to conserve any excess for the ward's needs.

(e) Unless waived by the court, a full guardian is required to report the condition of the ward and of the estate which has been subject to the full guardian's possession or control annually for the preceding year. A copy of the report must be served upon the ward's parent, child, or sibling if that person has made an effective request under 72-5-318.

(f) If a conservator has been appointed, all of the
ward's estate received by the full guardian in excess of those funds expended to meet current expenses for support, care, and education of the ward must be paid to the conservator for management as provided in this chapter, and the full guardian must account to the conservator for funds expended.

(3) Upon failure, as determined by the clerk of court, of the guardian to file an annual report, the court shall order the guardian to file the report and give good cause for the guardian's failure to file a timely report.

(4) Any full guardian of one for whom a conservator also has been appointed shall control the custody and care of the ward. A limited guardian of a person for whom a conservator has been appointed shall control those aspects of the custody and care of the ward over which the limited guardian is given authority by the order establishing the limited guardianship. The full guardian or limited guardian is entitled to receive reasonable sums for the guardian's services and for room and board furnished to the ward as agreed upon between the guardian and the conservator, provided the amounts agreed upon are reasonable under the circumstances. The full guardian or limited guardian authorized to oversee the incapacitated person's care may request the conservator to expend the ward's estate by payment to third persons or institutions for the ward's care and maintenance.

(5) A full guardian or limited guardian may not involuntarily commit for mental health treatment or for treatment of a developmental disability or for observation or evaluation a ward who is unwilling or unable to give informed consent to commitment, except as provided in 72-5-322, unless the procedures for involuntary commitment set forth in Title 53, chapters 20 and 21, are followed. This chapter does not abrogate any of the rights of mentally disabled persons provided for in Title 53, chapters 20 and 21.

(6) Upon the death of a full guardian's or limited guardian's ward, the full guardian or limited guardian, upon an order of the court and if there is no personal representative authorized to do so, may make necessary arrangements for the removal, transportation, and final disposition of the ward's physical remains, including burial, entombment, or cremation, and for the receipt and disposition of the ward's clothing, furniture, and other personal effects that may be in the possession of the person in charge of the ward's care, comfort, and maintenance at the time of the ward's death.


OFFICIAL COMMENTS

The guardian is responsible for the care of the person of his ward. This section gives him the powers necessary to carry out this responsibility. Where there are no protective proceedings, the guardian also has limited authority over the property of the ward. Where the ward has substantial property, it may be desirable to have protective proceedings to handle his property problems. The same person, of course, may serve as guardian and conservator. Section [72-5-421] authorizes the court to make preliminary orders protecting the estate once a petition for appointment of a conservator is filed.

HISTORICAL AND STATUTORY NOTES

Laws 2007, ch. 480, § 2, added the second through fourth sentences of subsec. (2)(c) providing: "This subsection (2)(c) does not authorize a full guardian to consent to the withholding or withdrawal of life sustaining treatment or to a do not resuscitate order if the full guardian does not have authority to consent pursuant to the Montana Rights of the Terminally Ill Act, Title 50, chapter 9, or to the do not resuscitate provisions of Title 50, chapter 10. A full guardian may petition the court for authority to consent to the withholding or withdrawal of life-sustaining treatment or to a do not resuscitate order. The court may grant that authority only upon finding that consent to the withholding or withdrawal of life-sustaining treatment or the do not resuscitate order is consistent with the ward's wishes to the extent that those wishes can be determined."

Laws 2009, ch. 237, § 2, in par. (2)(c), in the third sentence, inserted "not" and substituted "if it conflicts" for "only upon finding that consent to the withholding or withdrawal of life-sustaining treatment or the do-not-resuscitate order is consistent" and added the fourth sentence.

CROSS REFERENCES
Rights of the Terminally Ill Act, see § 50-9-101 et seq.

Withholding or withdrawal of treatment, consent by others, see § 50-9-106.

LIBRARY REFERENCES

Chemical Dependents §3.
Guardian and Ward §28 to 59.
Mental Health §179 to 236.
Westlaw Key Number Searches: 76Ak3; 196k28 to 196k59; 257Ak179 to 257Ak236.
C.J.S. Chemical Dependents § 3.
C.J.S. Guardian and Ward §§ 51 to 56, 58 to 91, 100, 103 to 132.
C.J.S. Mental Health §§ 176 to 179, 183 to 207.

NOTES OF DECISIONS

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1. Limited guardianship

Where review of findings of fact, which were supported by record, indicated that condition of incapacitated person was so serious that limited guardianship or conservatorship would not have been sufficient to adequately provide for her protection and care, district court's intention to create full guardianship was obvious and its order would be amended to specify that full guardianship was created. MCA 72-5-305(3), 72-5-316(2), 72-5-321. Matter of Guardianship of Nelson, 1983, 204 Mont. 90, 663 P.2d 316 Mental Health §157

2. Accounting

Where a guardian of two minors L. and E. admitted that a loan originally belonged to E.'s account, but that he transferred it to the account of L., without order of court, he could not, on the final settlement of E.'s account, complain of an order directing him to account to E. for the interest on the loan from the date of the transfer. In re Allard, 1914, 49 Mont. 219, 141 P. 661. Guardian And Ward §147

Where a guardian for more than 13 years failed to render any account required annually by Code Civ.Proc.1895, §§ 2985, 2986 (Rev.Codes, §§ 7774, 7775), and did not make any inventory, the court, limited to his testimony to ascertain the facts as to his guardianship, properly denied him compensation for services. In re Allard, 1914, 49 Mont. 219, 141 P. 661. Guardian And Ward §150

Under Rev.Codes, §§ 3786, 3787, 7771, 7783, 7795, defining the duties of guardians, and section 5375, declaring that a trustee may not deal with the trust property for his own benefit, a guardian must account for all accumulations from the use of guardianship funds, and he may not profit from their use, and he may be compelled to account for interest on a loan evidenced by a note, though the ward refuses to accept the note. In re Allard, 1914, 49 Mont. 219, 141 P. 661. Guardian And Ward §150

3. Compensation

Rev.Codes, § 7777, providing for compensation to a guardian, contemplates faithful performance of duty, and while a mere technical default may not deprive him thereof, where he is guilty of a flagrant violation of his duties, he may be denied compensation for his services. In re Allard, 1914, 49 Mont. 219, 141 P. 661. Guardian And Ward §150

Where a guardian mingled guardianship funds with his own funds, and within little more than a year after his appointment withdrew from his account as guardian a large sum, without disclosing the purpose therefor, the court properly denied him compensation for services as guardian. In re Allard, 1914, 49 Mont. 219, 141 P. 661. Guardian And Ward §150

4. Marital dissolution

Legal guardian did not have the power to file a marital dissolution proceeding on behalf of incapacitated ward; statute provided that guardian for an incapacitated person had the same rights and powers that a parent has with respect to an unemancipated child, statute was specific while Rule of Civil Procedure that dealt with a guardian's powers was general, and an unemancipated child was a child that was not married. MCA 72-5-321; Rules Civ.Proc., Rule 17(c). In re Marriage of Denowh ex rel. Deck, 2003, 317 Mont. 314, 78 P.3d 63, rehearing denied. Guardian And Ward §29

5. Loans by guardian
The rule that a guardian making a loan of his ward's funds must exercise due care will be applied much more strictly against a guardian who makes a loan on his own responsibility than where he makes a loan at the direction of the court. In re Allard, 1914, 49 Mont. 219, 141 P. 661, Guardian And Ward

6. Mismanagement of funds

A guardian mingling guardianship funds with his own, or profiting by the use of the funds of the ward, should be summarily removed. In re Allard, 1914, 49 Mont. 219, 141 P. 661, Guardian And Ward

A guardian may not mingle guardianship funds with his own private funds. In re Allard, 1914, 49 Mont. 219, 141 P. 661, Guardian And Ward

7. Attorney fees

The allowance of attorney's fees on final settlement of a guardian's account is in the control of the trial court's discretion, and its action will not be disturbed in the absence of clear abuse. In re Allard, 1914, 49 Mont. 219, 141 P. 661, Guardian And Ward

MCA 72-5-321, MT ST 72-5-321

Current through all 2009 legislation

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END OF DOCUMENT
72-5-322. (Temporary) Petition of guardian for treatment of ward

(1) If a guardian believes that the guardian's ward should receive medical treatment for a mental disorder and the ward refuses, the court may, upon petition by the guardian, grant an order for evaluation or treatment. However, the order may not forcibly detain the ward against the ward's will for more than 72 hours.

(2) The ward is entitled to an appointment of counsel and a hearing along with all the other rights guaranteed to a person with a mental disorder and who requires commitment under 53-21-114, 53-21-115, 53-21-119, and 53-21-120.
72-5-501. When power of attorney not affected by disability

(1) A durable power of attorney is a power of attorney by which a principal designates another his attorney-in-fact or agent in writing and the writing contains the words, "This power of attorney shall not be affected by subsequent disability or incapacity of the principal or lapse of time" or "This power of attorney shall become effective upon the disability or incapacity of the principal" or similar words showing the intent of the principal that the authority conferred shall be exercisable notwithstanding the principal's subsequent disability or incapacity, and, unless it states a time of termination, notwithstanding the lapse of time since the execution of the instrument. All acts done by the attorney-in-fact pursuant to a durable power of attorney during any period of disability or incapacity of the principal have the same effect and inure to the benefit of and bind the principal and his successors in interest as if the principal were alive, competent, and not disabled. Unless the instrument states a time of termination, the power is exercisable notwithstanding the lapse of time since the execution of the instrument.

(2) If a conservator thereafter is appointed for the principal, the attorney-in-fact or agent, during the continuance of the appointment, is accountable to the conservator as well as the principal. The conservator has the same power to revoke or amend the power of attorney that the principal would have had if he were not disabled or incapacitated. A principal may nominate, by a durable power of attorney, the conservator of his estate or guardian of his person for consideration by the court if protective proceedings for the principal's person or estate are later commenced. The court shall make its appointment in accordance with the principal's most recent nomination in a durable power of attorney except for good cause or disqualification.


NOTES, REFERENCES, AND ANNOTATIONS

Official Comments

[The first sentence of subsection (1)], derived from the first sentence of UPC 5-501 (1969) (1975), is a definitional section that supports use of the term "durable power of attorney" in the sections that follow. The second quoted expression was designed to emphasize that a durable power with postponed effectiveness is permitted. Some UPC critics have been bothered by the reference here to a later condition of "disability or incapacity," a circumstance that may be difficult to ascertain if it can be established without a court order. The answer, of course, is that draftsmen of durable powers are not limited in their choice of words to describe the later time when the principal wishes the authority of the agent in fact to become operative. For example, a durable power might be framed to confer authority commencing when two or more named persons, possibly including the principal's lawyer, physician or spouse, concur that the principal has become incapable of managing his affairs in a sensible and efficient manner and deliver a signed statement to that effect to the attorney in fact.

In this and following sections, it is assumed that the principal is competent when the power of attorney is signed. If this is not the case, nothing in this Act is intended to alter the result that would be reached under general principles of law. [The second sentence of subsection (1)] is derived from the second sentence of UPC 5-501 (1969) (1975) modified by deleting reference to the effect on a durable power of the principal's death, a matter that is now covered in Section [4] [5-504] which provides a single standard for durable and non-durable powers. [Note: the Montana version does not have this deletion, and retains both standards.]

The words "any period of disability or incapacity of the principal" are intended to include periods during which the principal is legally incompetent, but are not intended to be limited to such periods. In the Uniform Probate Code, the word "disability" is defined, and the term "incapacitated person" is defined. In the context of this section, however, the important point is that the terms embrace "legal incompetence," as well as less grievous disadvantages.
form of accounting. Hence, the context differs from those involving statutory duties to account in court, or with specified frequency, where draftsmen of controlling instruments may be able to excuse statutory details relating to accountings without affecting the general principle of accountability.

**Compiler's Comments**

1989 Amendment: In (1), in second sentence after "attorney-in-fact", deleted "or agent", substituted "pursuant to a durable power of attorney" for "pursuant to the power", after "disability or incapacity" substituted "of the principal" for "or uncertainty as to whether the principal is dead or alive", and inserted last sentence relating to exercise of power notwithstanding lapse of time from execution of the instrument; and made minor changes in phraseology.


1985 Amendment: Substituted entire section (see 1985 Session Law for text) for former text that read: "(1) Whenever a principal designates another his attorney-in-fact or agent by a power of attorney in writing and the writing contains the words, "This power of attorney shall become effective upon the disability of the principal" or "This power of attorney shall become effective upon the disability of the principal" or similar words showing the intent of the principal that the authority conferred shall be exercisable notwithstanding his disability, the authority of the attorney-in-fact or agent is exercisable by him as provided in the power on behalf of the principal notwithstanding later disability or incapacity of the principal at law or later uncertainty as to whether the principal is dead or alive. All acts done by the attorney-in-fact or agent pursuant to the power during any period of disability or incompetence or uncertainty as to whether the principal is dead or alive have the same effect and inure to the benefit of and bind the principal or his heirs, devisees, and personal representative as if the principal were alive, competent, and not disabled.

(2) If a conservator thereafter is appointed for the principal, the attorney-in-fact or agent, during the continuance of the appointment, shall account to the conservator rather than the principal. The conservator has the same power the principal would have had if he were not disabled or incompetent to revoke,
MCA 72-5-501, MT ST 72-5-501

suspend, or terminate all or any part of the power of attorney or agency."

Source: This section is derived from sections 1 through 3 of the Uniform Durable Power of Attorney Act, 8A U.L.A. 275, which in turn are a restatement of section 5-501 of the (1975) Uniform Probate Code.

Collateral References

Principal and Agent + 43(1).

Montana Probate Procedure (State Bar of Montana 1982-83) Form No. 36.

MCA 72-5-501, MT ST 72-5-501

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
72-5-502, Power of attorney not revoked until notice

(1) The death of a principal who has executed a written power of attorney, durable or otherwise, does not revoke or terminate the agency as to the attorney-in-fact, agent, or other person who, without actual knowledge of the death of the principal, acts in good faith under the power of attorney or agency. Any action so taken, unless otherwise invalid or unenforceable, binds the successors in interest of the principal.

(2) The disability or incapacity of a principal who has previously executed a power of attorney that is not a durable power does not revoke or terminate the agency as to the attorney-in-fact or other person who, without actual knowledge of the disability or incapacity of the principal, acts in good faith under the power. Any action so taken, unless otherwise invalid or unenforceable, binds the principal and his successors in interest.

(3) As to acts undertaken in good faith reliance thereon, an affidavit executed by the attorney-in-fact or agent stating that he did not have, at the time of exercise of the power, actual knowledge of the termination of the power by revocation or of the principal's death, disability, or incapacity is conclusive proof of the nonrevocation or nontermination of the power at that time. If the exercise of the power requires execution and delivery of any instrument which is recordable, the affidavit when authenticated for record is likewise recordable.

(4) This section does not affect any provision in a power of attorney for its termination by expiration of time or occurrence of an event other than express revocation or a change in the principal's capacity.


NOTES, REFERENCES, AND ANNOTATIONS

Official Comments

UPC §§ 5-501 and 5-502 (1969) (1975) are flawed by different standards for durable and non-durable powers vis a vis the protection of an attorney in fact who purports to exercise a power after the principal has died. Section 5-501 (1969) (1975), applicable only to durable powers, expresses a most unsatisfactory standard; i.e., the attorney in fact is protected if the exercise occurs "during any period of uncertainty as to whether the principal is dead or alive. . . ." Section 5-502 (1969) (1975), applicable only to non-durable powers, protects the agent who "without actual knowledge of the death . . . of the principal, acts in good faith under the power of attorney . . . ." Section [4] [5-504] (a) expresses as a single test the standard now contained in § 5-502 (1969) (1975). [Note: the Montana version retains both standards.]

Subsection [2], applicable only to non-durable powers that are controlled by the traditional view that a principal's loss of capacity ends the authority of his agents, embodies the substance of UPC § 5-502 (1969) (1975).

The discussion in the Committee of the Whole established that the language "or other person" in subsections [(1) and (2)] is intended to refer to persons who transact business with the attorney in fact under the authority conferred by the power. Consequently, persons in this category who act in good faith and without the actual knowledge described in the subsections are protected by the statute.

Also, there was discussion of possible conflict between the actual knowledge test here prescribed for protection of persons relying on the continuance of a power and constructive notice concepts under statutes governing the recording of instruments affecting real estate. The view was expressed in the Committee of the Whole that the recording statutes would continue to control since those statutes are specifically designed to encourage public recording of documents affecting land titles. It was also suggested that "good faith," as required by this section, might be lacking in the unlikely case of one who, without actual knowledge of the principal's death or incompetency, accepted a conveyance executed by an attorney in fact without checking the public record where he would have found an instrument disclosing the
principal's death or incompetency. If so, there would be no conflict between this act and recording statutes.

It is to be noted, also, that [subsections (1) and (2) deal] only with the effect of a principal's death or incompetency as a revocation of a power of attorney; [they do] not relate to an express revocation of a power or to the expiration of a power according to its terms. Further, since a durable power is not revoked by incapacity, the section's coverage of revocation of powers of attorney by the principal's incapacity is restricted to powers that are not durable. The only effect of the Act on rules governing express revocations of powers of attorney is as described in Section [5] [5-505].

[Subsections (3) and (4)], embodying the substance and form of UPC 5-502(b) (1969) (1975), [have] been extended to apply to durable powers. It is unclear whether UPC 5-502(b) (1969) (1975) applies to durable powers. Affidavits protecting persons dealing with attorneys in fact extend the utility of powers of attorney and plainly should be available for use by all attorneys in fact.

The matters stated in an affidavit that are strengthened by [subsections (3) and (4)] are limited to the revocation of a power by the principal's voluntary act, his death, or, in the case of non-durable power, by his incompetence. With one possible exception, other matters, including circumstances made relevant by the terms of the instrument to the commencement of the agency or to its termination by other circumstances, are not covered. The exception concerns the case of a power created to begin on "incapacity." The affidavit of the agent in fact that all conditions necessary to the valid exercise of the power might be aided by the statute in relation to the fact of incapacity. An affidavit as to the existence or non-existence of facts and circumstances not covered by [subsections (3) and (4)] nonetheless may be useful in establishing good faith reliance.

Compiler's Comments

1985 Amendment: Substituted entire section (see 1985 Session Law for text) for former text that read: "(1) The death, disability, or incompetence of any principal who has executed a power of attorney in writing other than a power as described by 72-5-501 does not revoke or terminate the agency as to the attorney-in-fact, agent, or other person who, without actual knowledge of the death, disability, or incompetence of the principal, acts in good faith under the power of attorney or agency. Any action so taken, unless otherwise invalid or unenforceable, binds the principal and his heirs, devisees, and personal representatives.

(2) An affidavit executed by the attorney-in-fact or agent stating that he did not have, at the time of doing an act pursuant to the power of attorney, actual knowledge of the revocation or termination of the power of attorney by death, disability, or incompetence is, in the absence of fraud, conclusive proof of the nonrevocation or nontermination of the power at that time. If the exercise of the power requires execution and delivery of any instrument which is recordable, the affidavit when authenticated for record is likewise recordable.

(3) This section shall not be construed to alter or affect any provision for revocation or termination contained in the power of attorney."

Source: This section is derived from sections 4 and 5 of the Uniform Durable Power of Attorney Act, 8A U.L.A. 275, which in turn are a restatement of section 5-502 of the (1975) Uniform Probate Code.

Collateral References

Principal and Agent + 43(1).

MCA 72-5-502, MT ST 72-5-502

Current through the 2005 Regular Session of the 59th Legislature

END OF DOCUMENT
(1) The department of justice shall electronically transfer to the federally designated organ procurement organization all information that appears on the front of a driver's license, including the name, gender, date of birth, and most recent address of any person who obtains a driver's license and who volunteers to donate organs or tissue upon death, as provided in 61-5-301. The department of justice may charge actual costs for the first transfer of information, as provided in subsection (5). However, all subsequent electronic transfers of donor information must be at no charge to the federally designated organ procurement organization.

(2) Information obtained by the federally designated organ procurement organization must be used for the purpose of establishing a statewide organ and tissue donation registry accessible to in-state, recognized cadaveric organ and cadaveric tissue agencies for the recovery or placement of organs and tissue and to procurement agencies in another state when a Montana resident is a donor of an anatomical gift and is not located in the state at the time of death or immediately before the death of the donor.

(3) An organ or tissue donation organization may not obtain information from the organ and tissue donation registry for the purpose of fundraising. Organ and tissue donation registry information may not be further disseminated unless authorized in this section or by federal law. Dissemination of organ and tissue donation registry information may be made by the organ procurement organization to a recognized, in-state procurement agency for other tissue recovery or to an out-of-state, federally designated organ procurement organization.

(4) The federally designated organ procurement organization may acquire donor information from sources other than the department of justice.

(5) All reasonable costs associated with the creation and maintenance of the organ and tissue donation registry, as determined by the department of justice, must be paid by the organ and tissue procurement organizations. Any money collected by the department of justice must be deposited in an account in the state special revenue fund established by the department of justice for the purpose of the payment of reasonable costs associated with the development and maintenance of the organ and tissue donation registry and necessary for the initial installation and setup for electronic transfer of the donor information.

(6) An individual does not need to participate in the organ and tissue donation registry to be a donor of organs or tissue. The registry is intended to facilitate organ and tissue donation and not inhibit persons from being donors upon death.

History: En. Sec. 2, Ch. 230, L. 2003.

NOTES, REFERENCES, AND ANNOTATIONS

Compiler's Comments

Preamble: The preamble attached to Ch. 230, L. 2003, provided: "WHEREAS, more than 80,000 people are currently waiting for life-saving organ transplants on the national transplant waiting list, of which 1,200 persons live in our region, and 17 people die each day as a result of the shortage of donated organs."

Effective Date: This section is effective October 1, 2003.
MCA 72-17-108, MT ST 72-17-108

West's Montana Code Annotated Currentness
Title 72. Estates, Trusts, and Fiduciary Relationships
Chapter 17. Anatomical Gift Act (Refs & Annos)

72-17-108. Coordination of procurement and use

Each hospital in this state shall establish agreements or affiliations with procurement organizations for coordination of procurement and use of anatomical gifts.


OFFICIAL COMMENTS

Among the recommendations of the Task Force pursuant to the 1984 National Organ Transplant Act, was the following:

"The Joint Commission on the Accreditation of Hospitals develop [sic] a standard that requires all acute care hospitals to both have an affiliation with an organ procurement agency and have formal policies and procedures for identifying potential organ and tissue donors and providing next of kin with appropriate opportunities for donation."

The failure of a hospital to establish the agreements or affiliations specified in this section will not affect gifts made to the hospital or gifts by patients in the hospital.

HISTORICAL AND STATUTORY NOTES

Laws 2007, ch. 345, § 6, rewrote this section that formerly provided:

"Each hospital in this state, after consultation with other hospitals and procurement organizations, shall establish agreements or affiliations for coordination of procurement and use of human bodies and parts."

Section 20 of Laws 2007, ch. 345 provides:

"Section 20. Applicability. [This act] applies to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift made before October 1, 2007."

LIBRARY REFERENCES

Dead Bodies 116k1.
Westlaw Key Number Search: 116k1.
C.J.S. Dead Bodies §§ 1 to 3.

MCA 72-17-108, MT ST 72-17-108

Current through all 2009 legislation

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END OF DOCUMENT
(1) An anatomical gift of a donor's body or part may be made during the life of the donor for the purpose of transplantation, therapy, research, or education in the manner provided in this section by:

(a) the donor if the donor is an adult or if the donor is a minor and is:

(i) emancipated; or

(ii) authorized under state law to apply for a driver's license because the donor is at least 15 years of age;

(b) an agent of the donor unless the power of attorney for health care or other record prohibits the agent from making an anatomical gift;

(c) a parent of the donor if the donor is an unemancipated minor; or

(d) the donor's guardian.

(2) A donor may make an anatomical gift:

(a) by authorizing a statement or symbol indicating that the donor has made an anatomical gift to be imprinted on the donor's driver's license or identification card;

(b) by a statement contained in a will;

(c) during a terminal illness or injury of the donor, by any form of communication addressed to at least two adults, at least one of whom is a disinterested witness; or

(d) as provided in subsection (3).

(3) A donor or other person authorized to make an anatomical gift under subsection (1) may make a gift by a donor card or other record signed by the donor or other person making the gift or by authorizing that a statement or symbol indicating that the donor has made an anatomical gift be included on a donor registry. If the donor or other person is physically unable to sign the record, the record may be signed by another individual at the direction of the donor or the other person and must:

(a) be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or other person; and

(b) state that it has been signed and witnessed as provided in subsection (3)(a).

(4) Revocation, suspension, expiration, or cancellation of a driver's license or identification card issued to a donor does not invalidate the anatomical gift.

(5) A document of gift may designate a particular physician or surgeon to carry out the appropriate procedures. In the absence of a designation or if the designee is not available, the donee or other person authorized to accept the anatomical gift may employ or authorize any physician, surgeon, technician, or enucleator to carry out the appropriate procedures.

(6) An anatomical gift by will takes effect upon the donor's death, whether or not the will is probated. If, after the donor's death, the will is declared invalid for testamentary purposes, the validity of the anatomical gift is unaffected. An anatomical gift made in accordance with this section is sufficient legal authority for procurement without additional authority from the donor or the donor's family or estate.

(7) Except as provided in subsection (17) and subject to subsection (14), a donor or other person authorized to make an anatomical gift under subsection (1) may amend or revoke an anatomical gift only by:

(a) a record signed by:

(i) the donor or the other person; or

(ii) subject to subsection (8), another individual acting at the direction of the donor...
or the other person if the donor or other person is physically unable to sign;

(b) any form of communication during a terminal illness or injury addressed to at least two adults, one of whom is a disinterested witness;

(c) the delivery of a signed statement to a specified donee to whom a document of gift had been delivered;

(d) a later-executed document of gift that amends or revokes a previous anatomical gift or portion of an anatomical gift, either expressly or by inconsistency; or

(e) destroying or canceling the document of gift or portion of the document of gift used to make the anatomical gift with the intent to revoke the anatomical gift.

(8) A record signed pursuant to subsection (7)(a)(ii) must:

(a) be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(b) state that it has been signed and witnessed as provided in subsection (8)(a).

(9) A donor shall notify the federally designated organ procurement organization of the destruction, cancellation, or mutilation of the document for the purpose of removing the person's name from the organ and tissue donation registry created in §72-17-105 and §72-17-106.

(10) The donor of an anatomical gift made by will may amend or revoke the anatomical gift in the manner provided for amendment or revocation of wills or as provided in subsection (7).

(11)(a) An individual may refuse to make an anatomical gift of the individual's body or part by:

(i) a writing signed in the same manner as a document of gift;

(ii) a statement attached to or imprinted on a donor's driver's license or identification card;

(iii) the individual's will, whether or not the will is admitted to probate or invalidated after the individual's death; or

(iv) any other writing used to identify the individual as refusing to make an anatomical gift.

(b) During a terminal illness or injury, the refusal may be an oral statement or other form of communication addressed to at least two adults, at least one of whom is a disinterested witness.

(12) An individual who has made a refusal may amend or revoke a refusal:

(a) in the manner provided in subsection (11) for making a refusal;

(b) by subsequently making an anatomical gift pursuant to subsection (2) or (3) that is inconsistent with the refusal; or

(c) by destroying or canceling the record evidencing the refusal or the portion of the record used to make the refusal with the intent to revoke the refusal.

(13) Except as otherwise provided in subsection (17) and subject to subsection (15), in the absence of an express, contrary indication by the donor, a person other than the donor is barred from making, amending, or revoking an anatomical gift of a donor's body or part if the donor made an anatomical gift of the donor's body or part under subsection (2) or (3) or an amendment to an anatomical gift under subsection (7). The donor's family or health care provider may not refuse to honor the anatomical gift or thwart the procurement of the donation.

(14) Except as otherwise provided in subsection (18), in the absence of an express, contrary indication by the individual set forth in the refusal, an individual's unrevoked refusal to make an anatomical gift of the individual's body or a part bars all other persons from making an anatomical gift of the individual's body or a part.

(15) In the absence of an express, contrary indication by the donor or other person authorized under this section to make an anatomical gift, an anatomical gift of a part for one or more of the purposes set forth in subsection (1) is neither a refusal to give other parts nor a limitation on an anatomical gift under §72-17-214 or on a removal or release of other parts under §72-17-215.
(16) In the absence of contrary indications by the donor, a donor's revocation or amendment of an anatomical gift of the donor's body or part is not a refusal to make another anatomical gift and does not bar another person specified in 72-17-214 or this section from making an anatomical gift of the donor's body or part. If the donor intends a revocation to be a refusal to make an anatomical gift, the donor shall make the refusal pursuant to subsection (11).

(17) If a donor who is an unemancipated minor dies, a parent of the donor who is reasonably available may revoke or amend an anatomical gift of the donor's body or part.

(18) If an unemancipated minor who signed a refusal dies, a parent of the minor who is reasonably available may revoke the minor's refusal.


OFFICIAL COMMENTS

The major structural changes from the original Act are found in Sections 2 and 3 [72-17-201 and 72-17-214]. The persons who may make an anatomical gift are divided into the individual donor (new Section 2) [72-17-201] and next of kin or guardians of the person (new Section 3) [72-17-214]. The manner of executing (old Section 4) [72-17-204 and 72-17-205 (now repealed)], and amending or revoking (old Section 6) [72-17-209 (now repealed)] anatomical gifts are incorporated in new Section 2 [72-17-201] as well as provisions of other sections that involve "making, amending, revoking, and refusing to make anatomical gifts by the individual." Provisions of old Section 2 [72-17-201, 72-17-203 (now repealed), and 72-17-207] that do not relate directly to this topic have been shifted to later sections. In the original Act there is the following Comment:

"To minimize confusion there is merit in having a uniform provision throughout the country. Also it is desirable to enlarge the class of possible donors as much as possible. Subsection (a) of Section 2 [former 72-17-201(1)], providing that any person of sound mind and 18 years or more of age may execute a gift, will afford both nationwide uniformity and a desirable enlargement of the class of donors. Persons 18 years of age or more are of sufficient maturity to make the required decisions and the Uniform Act takes advantage of this fact."

In subsection (a) [72-17-201(1)] the Act has been expanded by inserting the right to refuse to make an anatomical gift. The absence of a donor card or the lack of an entry authorizing a gift on a driver's license are ambiguous and are not "contrary indications" of a decedent preventing an anatomical gift by next of kin under Section 2(b) [former 72-17-201(2)] of the original Act. This amendment and a provision specifying the manner of making a refusal (subsection (i)) [72-17-201(9)] provide the option to individuals who are definitely opposed to the donation for any purpose or of any part of their body as an anatomical gift. If the donor wishes to limit the anatomical gift to a specific purpose, e.g., transplantation, or to a specified part, e.g., eyes, the limitation must be stated clearly, i.e., "transplantation only," "eyes only."

Subsection (b) [72-17-201(2)] incorporates the provisions of Section 4(b) [72-17-204(2) (now repealed)] of the original Act. Section 4(a) [72-17-204(1) (now repealed)] of the original Act has been relocated to subsection (e) [72-17-201(5)] to reflect the change from using wills to choosing other forms of documents of gift to make anatomical gifts.

The requirement of two witnesses signing a donor card or other document of gift has been deleted to simplify the making of anatomical gifts. Self authentication of a document of gift by a donor who cannot sign relieves the donee of the duty to search for the witnesses upon death of the donor.

In the original Act there were several forms included in the Comments with this admonition:

"As the Uniform Act becomes widely accepted it will prove helpful if the forms by which gifts are made are similar in each of the participating states. Such forms should be as simple and understandable as possible."

The forms in these Comments are suggested for the 1987 Act.

ANATOMICAL GIFT BY A LIVING DONOR

Pursuant to the Anatomical Gift Act, upon my death, I hereby give (check boxes applicable):

1. [ ] Any needed organs, tissues, or parts;
MCA 72-17-201, MT ST 72-17-201

2. [ ] The following organs, tissues, or parts only __________________________;

3. [ ] For the following purposes only

________________________________________________________________________  __________________________

(transplant-therapy-research-education)

Date of Birth

Signature of Donor

Date Signed

Address of Donor

INSTRUCTIONS
Check box 1 if the gift is unrestricted, i.e., of any organ, tissue, or part for any purpose specified in the Act; do not check box 2 or box 3. If the gift is restricted to specific organ(s), tissue(s), or part(s) only, e.g., heart, cornea, etc., check box 2 and write in the organ or tissue to be given. If the gift is restricted to one or more of the purposes listed, e.g., transplant, therapy, etc., check box 3 and write in the purpose for which the gift is made.

A gift category included in some forms "of my body for anatomical study if needed" has not been included. Although a gift of the entire body is authorized by the Act, the exercise of this option usually requires an agreement with a medical school before a gift is made.

A simple form of refusal under the Act could provide:

Pursuant to the Anatomical Gift Act, I hereby refuse to make any anatomical gift.

Signature

INSTRUCTIONS
See Section 2(b) [72-17-201(2)] Comments. If the applicant for a driver's license refuses to make any anatomical gift, check box 4 only.

Subsection (d) [72-17-201(4)] is Section 4(d) [72-17-206 (now repealed)] of the original Act.

Subsection (e) [72-17-201(5)] is a restatement of Section 4(a) [72-17-204(1) (now repealed)] of the original Act.

Subsection (f) [72-17-201(6)] is a restatement of Section 6(a) and (b) [72-17-209(1) and (2) (now repealed)] of the original Act.

Subsection (g) [72-17-201(7)] is Section 6(a) [72-17-209(1) (now repealed)] of the original Act.
Subsection (h) [72-17-201(8)] states expressly the intention of the original Act that an anatomical gift not revoked by the donor cannot be revoked after the donor's death by any other person. This was explicit in the Comments to the original Act: "Subsection (e) [of Section 2] [72-17-203 (now repealed)] recognizes and gives legal effect to the right of the individual to dispose of his own body without subsequent veto by others." The Hastings Center Report cited the results of a telephone survey of organ procurement agencies in the United States in 1983 as follows:

"... the survey revealed that few transplant centers were willing to procure organs solely on the basis of a donor card or driver's license consent by the deceased. In situations in which family members could not be located, less than twenty-five percent of the respondents said they would proceed with organ procurement despite the presence of a written directive."

This subsection removes any uncertainty.

Subsection (i) [72-17-201(9)] expands the original Act by providing a method of refusing to make an anatomical gift. A potential donor has several options. The donor may make an anatomical gift (Section 2(a)) [72-17-201(1)], may express or imply a contrary indication that an anatomical gift shall not be made (Section 2(j)(k)) [72-17-201(10) and (11)], or may refuse to make an anatomical gift (Section 2(i)) [72-17-201(9)]. Contrary indications may include membership in organizations that do not approve of organ donation, statements or actions by the potential donor that are inconsistent with organ donations, etc. To be effective as a limitation on a gift by next of kin under Section 3 [72-17-214] or on a release of a part by other persons under Section 4 [72-17-215], after death, the contrary indications must be known to the persons authorized to act under Sections 3 and 4 [72-17-214 and 72-17-215]. The option of refusal to make an anatomical gift provided for by subsection (i) [72-17-201(9)] is a method of documenting contrary indications that might not be communicated otherwise and therefore not effective as a limitation on next of kin and other persons authorized to give or release a part under Sections 3 and 4 [72-17-214 and 72-17-215] of the Act. If the potential donor is unable to speak because of paralysis or other disability, any form of communicating a refusal is sufficient, e.g., responding to a direct inquiry by a nod of the head, squeeze of the hand, blink of eyes, etc.

Subsection (j) [72-17-201(10)] addresses the problem of donor cards that have been circulated by various organizations and that appear to limit the anatomical gift to only one organ, e.g., eyes, kidneys, etc. This type of card should not be construed as an expression of the intention of the donor to limit the anatomical gift to that organ only, in the absence of a refusal to give other organs or of other contrary indications.

Subsection (k) [72-17-201(11)] provides that a revocation of an anatomical gift made previously by a donor is neither a refusal to make any anatomical gift nor a contrary indication by the donor that no part shall be given or released for any purpose authorized by the Act. It merely restores the donor to the status of an individual who has neither made nor refused to make an anatomical gift. In the absence of any other action or contrary indication by that individual before death, the next of kin or guardian of the person may make an anatomical gift pursuant to Section 3 [72-17-214] or the appropriate person may authorize release and removal of a part pursuant to Section 4 [72-17-215].

An amendment of an anatomical gift made previously by the donor, whether the amendment relates to a part or a purpose, is not a refusal nor a limitation on a gift or release of other parts for any purpose specified in the Act. If the amendment is intended to be a refusal it must be expressed clearly as provided in subsection (i) [72-17-201(9)].

Revocation or amendment of a previous anatomical gift is ambiguous. It does not indicate an intention of the donor to refuse to make an anatomical gift. This subsection removes that ambiguity.

HISTORICAL AND STATUTORY NOTES

Laws 2007, ch. 345, § 7, rewrote this section that formerly provided:

"(1) An individual who is at least 18 years of age may:

"(a) make an anatomical gift for any of the purposes stated in 72-17-202; or

"(b) limit an anatomical gift to one or more of those purposes.

"(2) An anatomical gift may be made only by a document of gift signed by the donor. If the donor cannot sign, the document of gift must be signed by another individual and by two witnesses, all of whom have signed at the direction and in the presence of the
donor and of each other, and must state that it has been signed.

"(3) If a document of gift is attached to or imprinted on a donor's motor vehicle operator's license, the document of gift must comply with subsection (2). Revocation, suspension, expiration, or cancellation of the license does not invalidate the anatomical gift.

"(4) A document of gift may designate a particular physician or surgeon to carry out the appropriate procedures. In the absence of a designation or if the designee is not available, the donee or other person authorized to accept the anatomical gift may employ or authorize any physician, surgeon, technician, or enucleator to carry out the appropriate procedures.

"(5) An anatomical gift by will takes effect upon the death of the testator, whether or not the will is probated. If, after the testator's death, the will is declared invalid for testamentary purposes, the validity of the anatomical gift is unaffected. A gift made in accordance with this section is sufficient legal authority for procurement without additional authority from the donor or the donor's family or estate.

"(6)(a) A donor may amend or revoke an anatomical gift not made by will only by:

"(i) a signed statement;

"(ii) an oral statement made in the presence of two individuals;

"(iii) any form of communication during a terminal illness or injury addressed to a physician or surgeon; or

"(iv) the delivery of a signed statement to a specified donee to whom a document of gift had been delivered,

"(b) A donor shall notify the federally designated organ procurement organization of the destruction, cancellation, or mutilation of the document for the purpose of removing the person's name from the organ and tissue donation registry created in 72-17-105 and 72-17-106.

"(7) The donor of an anatomical gift made by will may amend or revoke the gift in the manner provided for amendment or revocation of wills or as provided in subsection (6).

"(8) An anatomical gift that is not revoked by the donor before death is irrevocable and does not require the consent or concurrence of any person after the donor's death. The donor's family or health care provider may not refuse to honor the gift or thwart the procurement of the donation.

"(9)(a) An individual may refuse to make an anatomical gift of the individual's body or part by:

"(i) a writing signed in the same manner as a document of gift;

"(ii) a statement attached to or imprinted on a donor's motor vehicle operator's license; or

"(iii) any other writing used to identify the individual as refusing to make an anatomical gift.

"(b) During a terminal illness or injury, the refusal may be an oral statement or other form of communication.

"(10) In the absence of contrary indications by the donor, an anatomical gift of a part is neither a refusal to give other parts nor a limitation on an anatomical gift under 72-17-214 or on a removal or release of other parts under 72-17-215.

"(11) In the absence of contrary indications by the donor, a revocation or amendment of an anatomical gift is not a refusal to make another anatomical gift. If the donor intends a revocation to be a refusal to make an anatomical gift, the donor shall make the refusal pursuant to subsection (9)."

Section 20 of Laws 2007, ch. 345 provides:

"Section 20. Applicability. [This act] applies to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift made before October 1, 2007."

CROSS REFERENCES

Anatomical gift or living will declaration, indication on driver's license, see § 61-5-301.

ADMINISTRATIVE CODE REFERENCES

Minimum standards for a hospital: organ donation requests and protocols, see MT ADC 37.106.405.

LIBRARY REFERENCES

MONTANA CODE ANNOTATED
TITLE 72. ESTATES, TRUSTS, AND FIDUCIARY RELATIONSHIPS
CHAPTER 17. ANATOMICAL GIFT ACT
PART 2. EXECUTION AND OPERATION OF ANATOMICAL GIFT

72-17-202. Persons who may become donees -- purposes for which anatomical gifts may be made

(1) The following persons may become donees of anatomical gifts for the purposes stated if named in the document of gift:

(a) a hospital, surgeon, physician, or procurement organization, an accredited medical school, dental school, college, or university, or another appropriate person for education or research;

(b) subject to subsection (2), an individual designated by the person making the anatomical gift if the individual is the recipient of the part; or

(c) an eye bank or tissue bank.

(2) If an anatomical gift to an individual under subsection (1)(b) cannot be transplanted into the individual, the part passes in accordance with subsection (7) in the absence of an express, contrary indication by the person making the anatomical gift.

(3) If an anatomical gift of one or more specific parts or of all parts is made in a document of gift that does not name a person described in subsection (1) but identifies the purpose for which an anatomical gift may be used, the following rules apply:

(a) If the part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank.

(b) If the part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank.

(c) If the part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(d) If the part is an organ, an eye, or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate organ procurement organization.

(4) For the purpose of subsection (3), if there is more than one purpose of an anatomical gift set forth in the document of gift but the purposes are not set forth in any priority, the anatomical gift must be used for transplantation or therapy, if suitable. If the anatomical gift cannot be used for transplantation or therapy, the gift may be used for research or education.

(5) If an anatomical gift of one or more specific parts is made in a document of gift that does not name a person described in subsection (1) and does not identify the purpose of the gift, the gift may be used only for transplantation or therapy and the gift passes in accordance with subsection (7).

(6) If a document of gift specifies only a general intent to make an anatomical gift by words such as "donor", "organ donor", or "body donor" or by a symbol or statement of similar import, the gift may be used only for transplantation or therapy and the gift passes in accordance with subsection (7).

(7) For purposes of subsections (2), (5), and (6), the following rules apply:

(a) If the part is an eye, the gift passes to the appropriate eye bank.

(b) If the part is tissue, the gift passes to the appropriate tissue bank.

(c) If the part is an organ, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(8) An anatomical gift of an organ for transplantation or therapy, other than an anatomical gift under subsection (1)(b), passes to the organ procurement organization as custodian of the organ.

(9) If an anatomical gift does not pass pursuant to subsections (1) through (8) or the decedent's body or part is not used for transplantation, therapy, research, or education, custody of the body or part passes to the person under obligation to dispose of

the body or part.

(10) If the donee knows of the decedent's refusal or contrary indications to make an anatomical gift or that an anatomical gift by a member of a class having priority to act is opposed by a member of the same class or a prior class under 72-17-214, the donee may not accept the anatomical gift. For the purposes of this subsection, if a person knows that an anatomical gift was made on a document of gift, the person is considered to know of any amendment or revocation of the anatomical gift or any refusal to make an anatomical gift on the same document of gift.

(11) Except as otherwise provided in subsection (1)(b), nothing in this section affects the allocation of organs for transplantation or therapy.


OFFICIAL COMMENTS

Subsection (a) [72-17-202(1)] is Section 3 [former 72-17-202(1)] of the original Act changed to combine subsections (1) and (3) [former 72-17-202(1)(a) and (1)(c)] and to reverse the sequence of purposes for which anatomical gifts may be made, i.e., transplantation followed by therapy rather than education, research, therapy, or transplantation. This emphasizes transplantation as a primary purpose.

Subsection (b) [72-17-202(2)] is a restatement of Section 4(c) [72-17-205 (now repealed)] of the original Act which provided that the attending physician would be the donee under specified circumstances. Hospitals are substituted for the attending physician. This will facilitate coordination of procurement and utilization of the gift pursuant to Section 9 [72-17-108].

Subsection (c) [72-17-202(3)] is substantially Section 2(c) [72-17-201(4)] of the original Act. The last sentence has been deleted because it does not apply to donees or purposes.

HISTORICAL AND STATUTORY NOTES

Laws 2007, ch. 345, § 8, rewrote this section that formerly provided:

"(1) The following persons may become donees of anatomical gifts for the purposes stated:

"(a) a hospital, surgeon, physician, or procurement organization for medical or dental education, research, advancement of medical or dental science, therapy, or transplantation;

"(b) an accredited medical or dental school, college, or university for education, research, advancement of medical or dental science; or

"(c) a designated individual for therapy or transplantation needed by that individual.

"(2) An anatomical gift may be made to a designated donee or without designating a donee. If a donee is not designated or if the donee is not available or rejects the anatomical gift, the anatomical gift may be accepted by a hospital.

"(3) If the donee knows of the decedent's refusal or contrary indications to make an anatomical gift or that an anatomical gift by a member of a class having priority to act is opposed by a member of the same class or a prior class under 72-17-214, the donee may not accept the anatomical gift."

Section 20 of Laws 2007, ch. 345 provides:

"Section 20. Applicability. [This act] applies to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift made before October 1, 2007."

LIBRARY REFERENCES

Dead Bodies. Westlaw Key Number Search: 116k1.
Westlaw Key Number Search: 116k1. C.J.S. Dead Bodies §§ 1 to 3.

RESEARCH REFERENCES

 Treatises and Practice Aids


American Law of Products Liability 3d PS STATESTATS, State Statutes.

UNITED STATES CODE ANNOTATED

Organ transplantation, see 42 U.S.C.A. § 273 et seq.

MCA 72-17-202, MT ST 72-17-202
(1) At or near the time of death of a hospitalized patient, the hospital administrator or a representative designated by the administrator shall notify the appropriate procurement organization and, if the reason for death falls under 46-4-122, the coroner with jurisdiction of the imminent or actual death of the patient and, in collaboration with the procurement organization, shall ensure that a trained designated requester is readily available to discuss donation opportunities with a person authorized under 72-17-214 to make an anatomical gift. The person designated must be a representative of a procurement organization or a person who has had training provided by or approved by a procurement organization.

(2) When a hospital refers an individual at or near death to a procurement organization, the organization:

(a) shall make a reasonable search of the records of the department of justice and any donor registry that it knows exists for the geographical area in which the individual resides to ascertain whether the individual has made an anatomical gift;

(b) must be allowed reasonable access to information in the records of the department of justice to ascertain whether an individual at or near death is a donor; and

(c) may conduct any reasonable examination necessary to ensure the medical suitability of a part that is or could be the subject of an anatomical gift for transplantation, therapy, research, or education from a donor or a prospective donor. During the examination period, measures necessary to ensure the medical suitability of the part may not be withdrawn unless the hospital or procurement organization knows that the individual expressed a contrary intent.

(3) A hospital, as soon as practical after the arrival of an individual reasonably believed to be dead or near death, shall make a reasonable search of the individual for a document of gift or other information identifying the bearer as a donor or as an individual who has refused to make an anatomical gift if there is not immediately available any other source of that information.

(4) If a document of gift or evidence of refusal to make an anatomical gift is located by the search required by subsection (3) and the individual or body to whom it relates is taken to a hospital, the hospital must be notified of the contents and the document or other evidence must be sent to the hospital.

(5) If, at or near the time of death of a patient, a hospital knows that an anatomical gift has been made pursuant to 72-17-214(1) or a release and removal of a part has been permitted pursuant to 72-17-215 or that a patient or an individual identified as in transit to the hospital is a donor, the hospital shall notify the donee if one is named and known to the hospital; if not, it shall notify an appropriate procurement organization. The hospital shall cooperate in the implementation of the anatomical gift or release and removal of a part.

(6) A person who fails to discharge the duties imposed by this section is not subject to criminal or civil liability but may be subject to appropriate administrative sanctions.

(7) Upon the death of a minor who was a donor or had signed a refusal, unless a procurement organization knows the minor is emancipated, the procurement organization shall conduct a reasonable search for the parents of the minor and provide the parents with an opportunity to revoke
or amend the anatomical gift or revoke the refusal.

(8) Upon referral by a hospital under subsection (2), a procurement organization shall make a reasonable search for any person listed in §214 having priority to make an anatomical gift on behalf of a prospective donor. If a procurement organization receives information that an anatomical gift to any other person was made, amended, or revoked, it shall promptly advise the other person of all relevant information.


OFFICIAL COMMENTS

Each individual upon admission to a hospital is asked a series of routine questions, such as "Do you have insurance?" and "Are you allergic to any drugs?" Subsection (a) adds to the list a routine inquiry about organ donation. It requires that a question be asked to identify organ donors and mandates discussion about organ donation, after the consent of the attending physician, with those who answer in the negative. If there is an affirmative response, a request is made for the organ donor card, driver's license, or other document of gift to determine if there are limitations, e.g., of a particular part (eyes) or of a particular purpose (transplant only) and to place a copy in the medical record as evidence of a valid gift to be effective at death. Although the amendment is limited to the admission process of hospitals, doctors are encouraged to include a similar routine inquiry of patients in their office procedures and hospitals are encouraged to extend the routine inquiry to outpatient, emergency, minor surgery, and similar procedures that do not require admission to the hospital.

Among the major findings of the Hastings Center Report was the following:

"While many Americans believe that signing a donor card or other written directive assures that their wishes will be respected and acted upon, it does not.... Few, if any, organs are donated solely on the basis of donor cards or written directives. Written directives are only effective if hospital protocols and practices are designed to discover and act upon the contents of such directives."

Subsection (b) is a variation of the required request concept. All but a few states have passed a variety of the required request statutes since 1985. Some specify that next of kin be informed of the option to give, others that a request to give be made. Federal law requires written protocols by hospitals participating in Medicare or Medicaid that "assure that families of potential organ donors are made aware of the option of organ or tissue donation and their option to decline." Subsection (b) requires a discussion of the option and, if there is no response, a request to make an anatomical gift. No discussion or request is necessary if the medical record discloses a prior gift or a refusal to make a gift or if the gift would not be suitable according to accepted medical standards.

The requirement is imposed on the institution. The title of the chief executive officer should be substituted for [administrator]. "Representative" is not limited to employees of the hospital. It may be a doctor, organ procurement specialist, etc.

Subsection (c) is based upon the Uniform Duties to Disabled Persons Act promulgated by NCCUSL in 1972. The purpose of that Act is to provide, insofar as practicable, for a minimum level of duty towards persons in an unconscious state and toward those who are conscious but otherwise unable to communicate the existence of a condition requiring special treatment.

Subsection (d) reflects a conclusion of The Hastings Center Report:

"Donor cards are often not found at accident sites, and even when they are, they are rarely located in hospital settings when needed."

This subsection requires that the hospital be notified as soon as a document of gift or refusal is located and that it be sent to the hospital with the individual or the body to which it relates, not taken to the hospital at some later time. Notification of the hospital of the existence and the contents of the document will enable the hospital to notify the organ procurement organization if there is a gift, that there is a potential donor, and the limitations, if any, of the gift.

Subsection (e) incorporates a
recommendation of The Task Force Report pursuant to the National Organ Transplant Act of 1984 that "The Commission for Uniform State Laws develop model legislation that requires acute care hospitals to develop an affiliation with an organ procurement agency and to adopt routine inquiry policies and procedures." The present draft incorporates this recommendation in Sections 5 and 9 [72-17-213 and 72-17-108].

Subsection (f) [72-17-213(5)] encourages hospital accrediting agencies, law enforcement, and other state agencies that have existing disciplinary procedures to impose sanctions for failure to discharge the duties imposed by Section 5 [72-17-213].

HISTORICAL AND STATUTORY NOTES

Laws 2007, ch. 345, § 11, substantially rewrote this section that formerly provided:

"(1) If, at or near the time of death of a patient, there is no medical record that the patient has made or refused to make an anatomical gift, the hospital administrator or a representative designated by the administrator shall discuss the option to make or refuse to make an anatomical gift and request the making of an anatomical gift pursuant to 72-17-214(1). The request must be made with reasonable discretion and sensitivity to the circumstances of the family. A request is not required if the gift is not suitable, based upon accepted medical standards, for a purpose specified in 72-17-202 or if there are medical or emotional conditions under which the request would contribute to severe emotional distress. An entry must be made in the medical record of the patient, stating the name and affiliation of the individual making the request and the name, response, and relationship to the patient of the person to whom the request was made. The department shall adopt rules to implement this subsection.

"(2) The following persons shall make a reasonable search for a document of gift or other information identifying the bearer as a donor or as an individual who has refused to make an anatomical gift:

"(a) a law enforcement officer, fireman, paramedic, or other emergency rescuer finding an individual whom the searcher believes is dead or near death; and

"(b) a hospital, upon the admission of an individual at or near the time of death, if there is not immediately available any other source of that information.

"(3) If a document of gift or evidence of refusal to make an anatomical gift is located by the search required by subsection (2)(a) and the individual or body to whom it relates is taken to a hospital, the hospital must be notified of the contents and the document or other evidence must be sent to the hospital.

"(4) If, at or near the time of death of a patient, a hospital knows that an anatomical gift has been made pursuant to 72-17-214(1) or a release and removal of a part has been permitted pursuant to 72-17-215 or that a patient or an individual identified as in transit to the hospital is a donor, the hospital shall notify the donee if one is named and known to the hospital; if not, it shall notify an appropriate procurement organization. The hospital shall cooperate in the implementation of the anatomical gift or release and removal of a part.

"(5) A person who fails to discharge the duties imposed by this section is not subject to criminal or civil liability but is subject to appropriate administrative sanctions."

Section 20 of Laws 2007, ch. 345 provides:

"Section 20. Applicability. [This act] applies to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift made before October 1, 2007."

CROSS REFERENCES

Organ procurement program, see § 50-5-212.

LIBRARY REFERENCES

Dead Bodies C.J.S. Dead Bodies §§ 1 to 3.
MCA 72-17-202, **MT ST 72-17-202**

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B-429
(1) Subject to subsections (2) and (3), any member of the following classes of persons who is reasonably available, in the order of priority listed, may make an anatomical gift of all or a part of the decedent's body for a purpose authorized in 72-17-201(1) unless the decedent, at the time of death, had made an unrevoked refusal to make that anatomical gift as provided for in 72-17-201:

(a) an agent of the decedent at the time of death who could have made an anatomical gift under 72-17-201 immediately before the decedent's death;

(b) the spouse of the decedent;

(c) an adult son or daughter of the decedent;

(d) either parent of the decedent;

(e) an adult brother or sister of the decedent;

(f) adult grandchildren of the decedent;

(g) a grandparent of the decedent;

(h) a guardian of the person of the decedent at the time of death; and

(i) any other person having the authority to dispose of the decedent's body.

(2) If there is more than one member of a class listed in subsection (1)(a), (1)(c), (1)(d), (1)(e), (1)(f), (1)(g), or (1)(i) entitled to make an anatomical gift, an anatomical gift may be made by a member of the class unless that member or a person to which the gift can pass under 72-17-202 knows of an objection by another member of the class. If an objection is known, the anatomical gift may be made only by a majority of the members of the class who are reasonably available.

(3) An anatomical gift may not be made by a person listed in subsection (1) if:

(a) a person in a prior class is reasonably available at the time of death to make or to object to the making of an anatomical gift; or

(b) the person proposing to make an anatomical gift knows of a refusal by the decedent.

(4) An anatomical gift by a person authorized under subsection (1) must be made by:

(a) a document of gift signed by the person; or

(b) the person's telegraphic, recorded telephonic, other recorded message, or other form of communication from the person that is contemporaneously reduced to writing and signed by the recipient.

(5) Subject to subsection (6), an anatomical gift by a person authorized under subsection (1) may be amended or revoked orally or in a record by any member of a prior class who is reasonably available. If more than one member of the prior class is reasonably available, the gift may be:

(a) amended only if a majority of the reasonably available members agree to the amending of the gift; or

(b) revoked only if a majority of the reasonably available members agree to the revoking of the gift or if they are equally divided as to whether to revoke the gift.

(6) A revocation made under subsection (5) is effective only if, before an incision has been made for the removal of a part from the body of the decedent or before invasive procedures have begun to prepare the recipient, the procurement organization, transplant hospital, physician, surgeon, technician, or enucleator removing the part knows of the revocation.

(7) A failure to make an anatomical gift under subsection (1) is not an objection to the making of an anatomical gift.


OFFICIAL COMMENTS
Section 3 [72-17-214] combines Sections 2(b) and 4(e) [former 72-17-201(2) and 72-17-204(3) (now repealed)] of the original Act, clarifies the limited right of revocation by next of kin and provides for the effect of failure to make a gift by persons other than the donor. Subsection (a) [72-17-214(1)], as explained in Comments to the original Act:

"... spells out the right of survivors to make the gift. Taking into account the very limited time available following death for the successful removal of such critical tissues as the kidney, the liver, and the heart, it seems desirable to eliminate all possible question by specifically stating the rights of and the priorities among the survivors."

The Act defines an anatomical gift as one "to take effect upon or after death." Survivors may execute the necessary documents of gift even prior to death. The following form is suggested:

Anatomical Gift by Next of Kin
or Guardian of the Person

Pursuant to the Uniform Anatomical Gift Act, I hereby make this anatomical gift from the body of ________ (Name of Decedent) who died on ________ (Date) at __________ (Place) in ________ (City and State)

The marks in the appropriate squares and the words filled into the blanks below indicate my relationship to the decedent and my wishes respecting the gift.

I survive the decedent as [ ] spouse; [ ] adult son or daughter; [ ] parent; [ ] adult brother or sister; [ ] grandparent; [ ] guardian of the person. I hereby give (check boxes applicable):

[ ] Any needed organs, tissues, or parts;

[ ] The following organs, tissues, or parts only __________________________

___________________________

[ ] For the following purposes only __________________________

___________________________

Date __________ Signature of Survivor __________

INSTRUCTIONS

See Section 2(b) [72-17-201(2)] Comments.

As described in the Comments to the original Act, subsection (b) [72-17-214(2)]:

"... provides for the effect of indicated objections by the decedent, and differences of view among the survivors... In view of the fact that persons under 18 years of age are excluded from [Section 2](a) [former and current 72-17-201(1)], it is especially desirable to cover with care the status of survivors, so younger decedents may be included."

"Knows" is substituted for "actual notice" in subsection (b) [72-17-214(2)] and throughout the Act. Knowledge, i.e., what is known, is a more useful concept than actual notice, i.e., what should be known.

Subsection (c) [72-17-214(3)] is Section 4(e) [72-17-204(3) (now repealed)] of the original Act with the addition of "other form of communication."

Subsection (d) [72-17-214(4)] limits the right of revocation of a gift made by other survivors pursuant to subsection (a) [72-17-214(1)]. If there is no prior knowledge of the revocation by the individual removing the organ or tissue, the revocation is ineffective for any purpose and the anatomical gift may be procured and utilized as though no attempted revocation had occurred.

Subsection (e) [72-17-214(5)] is based on the concept that failure to act is ambiguous. This subsection removes that ambiguity. If a person of a prior class under subsection (a) [72-17-214(1)] is available but does not make a gift, subsection (e) [72-17-214(5)] authorizes a gift by a person of a lower class. If an anatomical gift is not made pursuant to Section 3 [72-17-214], the provisions of Section 4 [72-17-215] apply.

HISTORICAL AND STATUTORY NOTES

Laws 2007, ch. 345, § 12, substantially rewrote this section that formerly provided:

"(1) Any member of the following classes of persons, in the order of priority listed, may make an anatomical gift of all or a part of the decedent's body
MCA 72-17-214, MT ST 72-17-214

for an authorized purpose, unless the decedent, at the time of death, had made an unrevoked refusal to make that anatomical gift:

"(a) the spouse of the decedent;

"(b) an adult son or daughter of the decedent;

"(c) either parent of the decedent;

"(d) an adult brother or sister of the decedent;

"(e) a grandparent of the decedent; and

"(f) a guardian of the person of the decedent at the time of death.

"(2) An anatomical gift may not be made by a person listed in subsection (1) if:

"(a) a person in a prior class is available at the time of death to make an anatomical gift;

"(b) the person proposing to make an anatomical gift knows of a refusal or contrary indications by the decedent; or

"(c) the person proposing to make an anatomical gift knows of an objection to making an anatomical gift by a member of the person's class or a prior class.

"(3) An anatomical gift by a person authorized under subsection (1) must be made by:

"(a) a document of gift signed by the person; or

"(b) the person's telegraphic, recorded telephonic, or other recorded message, or other form of communication from the person that is contemporaneously reduced to writing and signed by the recipient.

"(4) An anatomical gift by a person authorized under subsection (1) may be revoked by any member of the same or a prior class if, before procedures have begun for the removal of a part from the body of the decedent, the physician, surgeon, technician, or enucleator removing the part knows of the revocation.

"(5) A failure to make an anatomical gift under subsection (1) is not an objection to the making of an anatomical gift."

Section 20 of Laws 2007, ch. 345 provides:

"Section 20. Applicability. [This act] applies to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift made before October 1, 2007."

LIBRARY REFERENCES

Dead Bodies 116k1.
Westlaw Key Number Search: 116k1.
C.J.S. Dead Bodies §§ 1 to 3.

MCA 72-17-214, MT ST 72-17-214

Current through all 2009 legislation

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END OF DOCUMENT
23.4.220. COLLECTION OF BLOOD SAMPLES FOR DRUG AND/OR ALCOHOL ANALYSIS

(1) Blood samples will be collected from living individuals only by persons authorized by current law, upon written request of a peace officer or officer of the court.

(2) The skin at the area of puncture must be thoroughly cleansed and disinfected with an aqueous solution of a nonvolatile antiseptic i.e. betadine, etc. Alcohol phenolic solution may not be used.

(3) The blood sample will be deposited in a clean dry container. The container should then be capped or stoppered, sealed and the following information provided:

(a) name of the subject,

(b) date of the collection,

(c) time of the collection,

(d) paper seal to be signed and dated.

(4) All blood samples must be of sufficient volume to provide accurate and repeatable analyses. Required volumes will be dependant on the current technology employed by the division. Any submitted sample not meeting the required sample volume will not be analyzed.

(5) The division will provide collection kits consisting of approved collection tubes and the appropriate request forms for collection of blood samples. The division reserves the right to accept or reject any blood sample submitted in a commercially available collection kit.

(6) The approved collection tube will be one that contains a preservative, sodium fluoride or its equivalent and an anticoagulant, potassium oxalate or its equivalent. The use of other types of collection tubes will be at the discretion of the division.

(7) When possible, the peace officer requesting the blood sample shall observe the collection of the sample so that he/she may attest to the sample's authenticity.

(History: Sec. 61-8-405, MCA; IMP, Sec. 61-8-405, MCA; NEW, 1991 MAR p. 1281, Eff. 7/26/91; AMD, 1995 MAR p. 119, Eff. 1/27/95; AMD, 2002 MAR p. 1482, Eff. 5/17/02.)
23.4.221. COLLECTION OF POSTMORTEM SAMPLES FOR DRUGS AND/OR ALCOHOL ANALYSIS

(1) Sampling of body substances other than blood, breath, or urine is considered valid only in postmortem cases. All postmortem body material must be obtained prior to the embalming process. The sample or samples must be taken by a physician, board certified pathologist, the county coroner or a designated representative of the county coroner.

(2) Whenever a postmortem blood sample is collected, all practical precautions to ensure a representative, uncontaminated sample must be employed. Care must be taken to avoid contamination of the sample by gastrointestinal contents if it is necessary to sample heart blood. There must be adequate mixing of the blood sample before withdrawal. If a heart blood sample is taken without autopsy, precautions against dilution of the blood with pleural or pericardial fluids must be employed.

(3) In any postmortem collection of blood, the primary sample for analysis shall be femoral blood. If such sample is unattainable, the next sample of choice shall be heart blood. If a heart blood sample is unattainable, the sample of choice will be urine. Any sample to be drawn will be an uncontaminated sample.

(4) In the event that no fluid samples can be preserved, tissue samples may be submitted. Preferred tissue samples to be brain, liver, lung and kidney.

(History: Sec. 61-8-405(6), MCA; IMP, Sec. 61-8-405(6), MCA; NEW, 1991 MAR p. 1281, Eff. 7/26/91; AMD, 1995 MAR p. 119, Eff. 1/27/95.)
37.8.808. DEAD BODY REMOVAL AUTHORIZATION

(1) A completed dead body removal authorization form must include, as a minimum:

(a) insofar as possible, the decedent's full name or, in the case of a fetal death, the full name of the mother;

(b) the place of death, including city, county, name and address of facility if applicable, address of a place which is not a named facility or the specific geographic location if an address does not exist;

(c) the date death occurred or was first discovered or date of delivery if a fetal death;

(d) a signed and dated authorization statement along with, if applicable, a signed and dated certification of oral authorization;

(e) a signed and dated statement of assumption of responsibility for filing the death or fetal death certificate; and

(f) social security number of the decedent.

(2) The physician, physician's designee, coroner having jurisdiction or mortician who authorizes the removal of a dead body or the remains of a fetal death from the place of death must complete a dead body removal authorization on the department's form and, before or at the time of removal, if the person authorizing removal is:

(a) a physician or physician's designee, give all three copies of the form to the person in charge of disposition;

(b) a coroner or mortician, retain a copy of the completed form and give the other two copies to the person in charge of disposition, unless (2)(c) applies; or

(c) also the person in charge of disposition, retain all three copies and comply with (3).

(3) The person who removes a dead body or the remains of a fetal death from the place of death must retain a copy of the completed department dead body removal authorization form for that removal and mail or otherwise deliver the remaining copy or copies to the local registrar within 48 hours of the body's removal.

(4) If the registrar receives more than one copy of a completed dead body removal authorization form, he must retain one copy and provide the other copy to the coroner having jurisdiction.

(History: Sec. 50-15-102, MCA; IMP, Sec. 50-15-102 and 50-15-405, MCA; NEW, 1993 MAR p. 3023, Eff. 1/1/94; TRANS, from DHES, 1997 MAR p. 1460; AMD, 2003 MAR p. 2441, Eff. 10/31/03.)
37.8.1801. REPORTABLE TUMORS

(1) The following tumors are designated as reportable:

(a) malignant neoplasm, with the exception of a basal or squamous carcinoma of the skin;

(b) skin cancer of the labia, vulva, penis or scrotum;

(c) benign tumor of the brain, including a:

(i) meningioma (cerebral meninges);

(ii) pinealoma (pineal gland); or

(iii) adenoma (pituitary gland);

(d) carcinoid tumor, whether malignant, benign or not otherwise specified (NOS).

(2) A benign tumor other than one of those listed in (1) may be reported to the department for inclusion in the tumor registry if prior approval has been obtained from the Department of Public Health and Human Services, Public Health and Safety Division, Montana Central Tumor Registry, 1400 Broadway, PO Box 202951, Helena, MT 59620-2951.

(3) A tumor which is otherwise reportable, but has been diagnosed and recorded using the words "questionable", "possible", "suggests" or "equivocal" is not considered a reportable tumor.

(4) Whenever records of a patient with a tumor which would be reportable, if confirmed, contain the words "suspect", "probable", "suspicious", "compatible with" or "consistent with" in reference to that tumor, the tumor is considered reportable.

(5) In order for the department to maintain current reporting, hospitals shall submit to the department information on reportable tumors within six months from the date of discharge; independent laboratories shall submit to the department information on reportable tumors within six months from the date the laboratory service associated with the tumor was rendered.
37.8.1802. REQUIRED RECORDS, INITIAL ADMISSION AND TREATMENT

(1) Whenever a hospital initially provides medical services to any patient relating to a tumor designated as reportable by ARM 37.8.1801, it must collect, record and make available to the department the following information about that patient:

(a) name and current address of patient;
(b) patient's address at time of diagnosis;
(c) social security number;
(d) name of spouse, if any;
(e) phone number;
(f) race, sex, marital status and religion (optional);
(g) age at diagnosis, place of birth and month, day and year of birth;
(h) name, address and phone number of friend or relative to act as contact, plus relationship of that contact to patient;
(i) date and place of initial diagnosis;
(j) primary site of tumor (paired organ);
(k) sequence of primary tumors if more than one;
(l) other primary tumors;
(m) method of confirming diagnosis;
(n) histology, including dates, place, histologic type and slide number;
(o) summary staging, including whether in situ, localized, regional, distant or unstaged, with no information;
(p) description of tumor and its spread, if any,

including size in centimeters, number of positive nodes, number of nodes examined and site of distant metastases;
(q) whether American joint committee on cancer (AJCC) staging is utilized, and if so, the findings of the staging;
(r) cumulative summary of all therapy directed at the subject tumor, including:
(i) date of therapy;
(ii) specific type of surgery or radiation therapy, if any; and details of chemical, hormonal or other kinds of treatment; and
(iii) if no therapy given, reason for lack of therapy;
(s) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence or recurring or status unknown;
(t) if recurrence of tumor, type and distant sites of first recurrence;
(u) names of physicians primarily and secondarily responsible for follow up;
(v) date of each follow up; and
(w) if patient has died, date of death, place, cause and whether autopsy performed.

(History: Sec. 50-15-706, MCA; IMP, Sec. 50-15-703, MCA; NEW, 1982 MAR p. 391, Eff. 2/26/82; TRANS, from DHES, 1997 MAR p. 1460; AMD, 2003 MAR p. 2441, Eff. 10/31/03.)

END OF DOCUMENT
37.8.1803. REQUIRED RECORDS, FOLLOW UP

(1) Whenever a patient for whom information has been provided to the tumor registry is admitted to the hospital providing the information on an inpatient or outpatient basis for further treatment related to the tumor for which original registration in the tumor registry was made, the hospital must keep on file the following information:

(a) patient's name, noting any change from previous records;

(b) any paired organ involvement, noting sequence;

(c) subsequent histology, including dates, place, histology type, slide number and procedure;

(d) date, type of procedure and findings of any surgery or other exploratory measure;

(e) date and type of any administration of radiation;

(f) date of any administration of hormones, chemotherapy, immunotherapy or any other kind of treatment;

(g) date of death and/or last follow up;

(h) if death has occurred, the place, cause and whether an autopsy was performed;

(i) if autopsy performed, its findings pertaining to cancer;

(j) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence or has recurred or status is unknown;

(k) if recurrence of tumor, type and distant sites of first recurrence; and

(l) names of those physicians primarily and secondarily responsible for follow up treatment.

(History:  Sec. 50-15-706, MCA; IMP,  Sec. 50-15-703, MCA; NEW, 1982 MAR p. 391, Eff. 2/26/82; TRANS, from DHES, 1997 MAR p. 1460; AMD, 2003 MAR p. 2441, Eff. 10/31/03.)
37.57.301. DEFINITIONS

As used in this subchapter, the following definitions apply:

1. “Health care facility” means a hospital or other facility licensed by or located in the state of Montana for the purpose of providing health care services, and which provides primary health care services for newborns at birth.

2. “Newborn” means an infant in the first 28 days of life.

3. “Newborn screening tests” are laboratory screening tests for the following conditions:

   a. Acylcarnitine Disorders:

      i. Fatty Acid Oxidation Disorders:

         A. Carnitine uptake defect;

         B. Long-chain L-3-OH acyl-CoA dehydrogenase deficiency;

         C. Medium-chain acyl-CoA dehydrogenase deficiency;

         D. Trifunctional protein deficiency; and

      ii. Organic Acidemia Disorders:

         A. 3-hydroxy-3-methylglutaryl-CoA lyase deficiency;

   b. Amino Acid Disorders:

      i. Argininosuccinic acidemia;

      ii. Citrullinemia;

      iii. Homocystinuria;

      iv. Maple syrup urine disease;

      v. Phenylketonuria; and

      vi. Tyrosinemia type I;

   c. Biotinidase deficiency;

   d. Classical galactosemia;

   e. Congenital adrenal hyperplasia;

   f. Congenital hypothyroidism;

   g. Cystic fibrosis; and

   h. Hemoglobinopathies, including:

      i. Hb S <<beta>> -thalassemia;

      ii. Hb SC disease; and

      iii. Hb SS disease.

(B) 3-Methylcrotonyl-CoA carboxylase deficiency;

(C) <<beta>>-ketothiolase deficiency;

(D) Glutaric acidemia type I;

(E) Isovaleric acidemia;

(F) Methylmalonic acidemia (Cbl A, B);

(G) Methylmalonic acidemia (mutase deficiency);

(H) Multiple carboxylase deficiency; and

(I) Propionic acidemia;

(b) Amino Acid Disorders:

   i. Argininosuccinic acidemia;

   ii. Citrullinemia;

   iii. Homocystinuria;

   iv. Maple syrup urine disease;

   v. Phenylketonuria; and

   vi. Tyrosinemia type I;

   c. Biotinidase deficiency;

   d. Classical galactosemia;

   e. Congenital adrenal hyperplasia;

   f. Congenital hypothyroidism;

   g. Cystic fibrosis; and

   h. Hemoglobinopathies, including:

      i. Hb S <<beta>> -thalassemia;

      ii. Hb SC disease; and

      iii. Hb SS disease.

History: 50-19-202, MCA; IMP. 50-19-203, MCA; 
Eff. 12/31/72; AMD. Eff. 5/6/74; AMD. 1985 MAR
ARM 37.57.301

p. 1612, Eff. 11/1/85; TRANS. from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1298, Eff. 7/1/03; AMD, 2008 MAR p. 44, Eff. 1/18/08.)

Mont. Admin. R. 37.57.301, MT ADC 37.57.301
MT ADC 37.57.301

END OF DOCUMENT
37.57.304. VERY LOW BIRTH WEIGHT (UNDER 1,500 GRAMS) NEWBORNS

(1) If a newborn is of very low birth weight, i.e., under 1,500 grams, a specimen of its blood must be taken for testing after 24 hours of age and no later than seven days of age, unless medically contraindicated, in which case the specimen must be taken as soon as the infant's medical condition permits.

(2) In the event that the newborn stays in a health care facility longer than 14 days following birth, a repeat congenital hypothyroid screening must be made either at the time of discharge if the stay is less than one month, or at one month of age if the stay is one month or longer.

(History: 50-19-202, MCA; IMP, 50-19-203, MCA; Eff. 12/31/72; AMD, Eff. 5/6/74; AMD, 1985 MAR p. 1612, Eff. 11/1/85; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1298, Eff. 7/1/03; AMD, 2008 MAR p. 44, Eff. 1/18/08.)
37.57.305. NEWBORNS OTHER THAN THOSE WITH VERY LOW BIRTH WEIGHT

(1) For newborns at birth weights of 1,500 grams or more, the required blood specimen must be taken between 24 and 72 hours of age.

(2) In the event the newborn is discharged from a health care facility prior to the third day of life, the blood specimen must be taken immediately before discharge and, in addition, if the newborn is discharged before it is 24 hours old:

   (a) another specimen must be taken and submitted to the department's laboratory between the fourth and 14th day of the newborn's life; and

   (b) the health care facility must:

      (i) explain the reasons why it is of utmost importance to return for these tests; and

      (ii) ensure that the parent or legal guardian of the newborn signs a statement assuming responsibility to cause a specimen to again be taken between the fourth and 14th day of life of the newborn and to submit it to the department for testing.

(3) If taking a specimen on any of the dates cited in (1) and (2) is medically contraindicated, the specimen must be taken as soon as possible thereafter as the medical condition of the newborn permits.

(History: 50-19-202, MCA; IMP, 50-19-203, MCA; Eff. 12/31/72; AMD, Eff. 5/6/74; AMD, 1985 MAR p. 1612, Eff. 11/1/85; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1537, Eff. 7/1/03; AMD, 2008 MAR p. 44, Eff. 1/18/08.)

Mont.Admin.R. 37.57.305, MT ADC 37.57.305
MT ADC 37.57.305
ARM 37.57.316

ADMINISTRATIVE RULES OF MONTANA
TITLE 37. DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES
CHAPTER 57. MATERNAL AND CHILD
HEALTH
SUB-CHAPTER 3. INFANT SCREENING
TESTS AND EYE TREATMENT

Current through June 09, 2009

37.57.316. ABNORMAL TEST RESULT

(1) If an initial test result on an infant's blood
specimen is outside the expected or normal range:

   (a) the department will report that fact within 24
       hours of test completion to the attending physician
       or midwife, or, if there is none or the physician or
       midwife is unknown, to the person who registered
       the infant's birth;

   (b) the person to whom the above report is made
       must ensure that within 48 hours of receiving the
       notification of an abnormal test result, a second
       blood specimen will be taken and submitted to the
       department for a second test.

(2) If the second test result is outside the expected or
normal range:

   (a) the department will provide the test results
       within 24 hours of test completion to the same
       person to whom the initial results were reported;

   (b) that person must ensure that a serum specimen
       from the infant is immediately sent either to the
       department or to another approved laboratory
       qualified to perform quantitative analysis for the
       substance in question;

   (c) if the specimen is sent to a laboratory other than
       the department's, the person who submits it must
       send the department a copy of the analysis report
       for the specimen within 24 hours after receiving
       the report.

(3) An approved laboratory includes any state or
territorial health department laboratory and any
laboratory within their jurisdictions which is
approved by them, a U.S. public health service

labatory, a laboratory operated by the U.S. Armed
Forces or Veteran's Administration, a Canadian
provincial public health laboratory, and any
laboratory licensed under the provisions of the
Clinical Laboratories Improvement Act of 1967, as
amended.

(History: 50-19-202, MCA; IMP, 50-19-203, MCA;
Eff. 12/31/72; AMD, Eff. 5/6/74; AMD, 1985 MAR
p. 1612, Eff. 11/1/85; TRANS, from DHES, 2001
MAR p. 398; AMD, 2003 MAR p. 1298, Eff. 7/1/03;
AMD, 2008 MAR p. 44, Eff. 1/18/08.)

Mont.Admin.R. 37.57.316, MT ADC 37.57.316
MT ADC 37.57.316

END OF DOCUMENT
ARM 37.57.320

Mont.Admin.R. 37.57.320

ARM 37.57.320

ADMINISTRATIVE RULES OF MONTANA
TITLE 37. DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
CHAPTER 57. MATERNAL AND CHILD HEALTH
SUB-CHAPTER 3. INFANT SCREENING TESTS AND EYE TREATMENT

Current through June 09, 2009

37.57.320. RESPONSIBILITIES OF REGISTRAR OF BIRTH: ADMINISTRATOR OF HEALTH CARE FACILITY

(1) Each person in charge of any health care facility and each person responsible under ARM 37.57.307 must:

(a) ensure that a blood specimen is taken from each newborn for which the health care facility or person is responsible, in conformity with this subchapter, for the purpose of performing newborn screening tests;

(b) be certain, prior to the discharge of the newborn, that the specimen to be forwarded to the laboratory is adequate for testing purposes;

(c) within 24 hours after the taking of the specimen, cause such specimen to be forwarded to the department's laboratory by first class mail or its equivalent; and

(d) record on the newborn's chart or file the date of taking of the test specimen and the results of the tests performed when reported by the department.

(History: 50-19-202, MCA; IMP, 50-19-203, MCA; Eff. 12/31/72; AMD, Eff. 5/6/74; AMD, 1985 MAR p. 1612, Eff. 11/1/85; TRANS, from DHES, 2001 MAR p. 398; AMD, 2008 MAR p. 44, Eff. 1/18/08.)

Mont.Admin.R. 37.57.320, MT ADC 37.57.320
MT ADC 37.57.320

END OF DOCUMENT
37.57.321. STATE LABORATORY: RESPONSIBILITY FOR TESTS

(1) Only those newborn screening tests performed by the department laboratory or, in the case described in ARM 37.57.316, a laboratory approved by the department, meet the requirements of 50-19-201, 50-19-202, 50-19-203, and 50-19-204, MCA.

(History: 50-19-202, MCA; IMP, 50-19-203, MCA; Eff. 12/31/72; AMD, Eff. 5/6/74; AMD, 1985 MAR p. 1612, Eff. 11/1/85; TRANS, from DHES, 2001 MAR p. 398; AMD, 2003 MAR p. 1298, Eff. 7/1/03; AMD, 2008 MAR p. 44, Eff. 1/18/08.)
ARM 37.85.414

ADMINISTRATIVE RULES OF MONTANA
TITLE 37. DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES
CHAPTER 85. GENERAL MEDICAID
SERVICES
SUBCHAPTER 4. PROVIDER
REQUIREMENTS
Current through June 30, 2005

37.85.414. MAINTENANCE OF RECORDS AND
AUDITING

(1) All providers of service must maintain records
which fully demonstrate the extent, nature and
medical necessity of services and items provided to
Montana medicaid recipients. The records must
support the fee charged or payment sought for the
services and items and demonstrate compliance with
all applicable requirements.

(a) All records which support a claim for a service or
item must be complete within 90 days after the date
on which the claim was submitted to medicaid for
reimbursement. A record that is required to be signed
and dated, including but not limited to an order,
prescription, certificate of medical necessity, referral
or progress note, is not complete until it has been
signed and dated.

(b) When reimbursement is based on the length of
time spent in providing the service, the records must
specify the time spent or the time treatment began
and ended for each procedure billed to the nearest
minute. Total time billed using one or multiple
procedure codes may not exceed the total actual time
spent with the medicaid client.

(c) These records must be retained for a period of at
least six years and three months from the date on
which the service was rendered or until any dispute
or litigation concerning the services is resolved,
whichever is later.

(d) In maintaining financial records, providers shall
employ generally accepted accounting methods.
Generally accepted accounting methods are those
approved by the national association of certified
public accountants.

(e) The department shall have access to all records
so maintained and retained regardless of a provider's
continued participation in the program.

(f) In the event of a change of ownership, the
original owner must retain all required records unless
an alternative method of providing for the retention
of records has been established in writing and
approved by the department.

(g) If a provider cannot provide medical records to
prove that a service billed to medicaid was provided
and meets all requirements for reimbursement, the
service will be deemed not to be provided and
reimbursable due to the lack of documentation, and
the department will recover all reimbursement paid to
the provider. This recovery is permissible regardless
of whether the documentation was destroyed or lost
due to an event such as, but not limited to, misplaced
records, a data processing failure, fire, earthquake,
flood, or other natural disaster. The provider must
have a backup system in place to allow recovery of
documentation destroyed or lost due to such events or
any other cause.

(h) These record keeping requirements are the
minimum requirements for records to support all
medicaid claims. In addition to complying with these
minimum requirements, providers must also comply
with any specific record keeping requirements
applicable to the type of service the provider
furnishes, which may be more restrictive than the
minimum requirements of this rule.

(2) In addition to the recipient's medical records, any
medicaid information regarding a recipient or
applicant is confidential and shall be used solely for
purposes related to the administration of the Montana
medicaid program. This information shall not be
divulged by the provider or his employees, to any
person, group, or organization other than those listed
below or a department representative without the
written consent of the recipient or applicant. In
addition, the provider must comply with the Health
Insurance Portability and Accountability Act of 1996
(HIPAA), 42 USC 1320d et seq., and the Uniform
Health Care Information Act, 50-16-501 et seq.,
MCA.

(3) The department, the designated review
organization, the legislative auditor, the department
of revenue, the medicaid fraud control unit, and their
legal representatives shall have the right to inspect or
evaluate the quality, appropriateness, and timeliness
of services performed by providers, and to inspect
and audit all records required by this rule.

(a) Upon the department's request for records, the
provider shall submit a true and accurate copy of
each record of the service or item being reviewed as
it existed within 90 days after the date on which the claim was submitted to medicaid.

(b) Refusal to permit inspection, evaluation or audit of services shall result in the imposition of provider sanctions in accordance with the rules of the department.

(4) The provisions of this rule specifying the length of time for which records must be retained shall not be construed as a limitation on the period in which the department may recover overpayments or impose sanctions.

(History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479; AMD, 2005 MAR p. 459, Eff. 4/1/05.)
ARM 37.86.104

ARM 37.86.104

ADMINISTRATIVE RULES OF MONTANA
TITLE 37. DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES
CHAPTER 86. MEDICAID PRIMARY CARE
SERVICES
SUBCHAPTER 1. PHYSICIAN SERVICES
Current through June 30, 2005

37.86.104. PHYSICIAN SERVICES, REQUIREMENTS

(1) These requirements are in addition to those rule provisions generally applicable to medicaid providers.

(2) The department or its designated review organization may conduct utilization and peer review of physician services.

(3) Physician services for conditions or ailments that are generally considered cosmetic in nature are not a benefit of the medicaid program except in such cases where it can be demonstrated that the physical and psycho-social well being of the recipient is severely affected in a detrimental manner by the condition or ailment. Such services must be prior authorized by the medicaid services bureau, based on recommendations of the designated peer review organization.

(a) A request for prior authorization must include all relevant information to justify the need for the service. This information includes statements from a physician qualified in the area of concern and a potential provider.

(b) The information must clearly document the necessity for the service and include assurances that the plan will be followed to completion.

(4) Coverage of physician services for sterilization is limited as follows:

(a) The recipient to be sterilized must not be declared mentally incompetent by a federal, state, or local court of law.

(b) The recipient to be sterilized must be 21 years of age or older at the time informed consent to sterilization is obtained from the recipient.

(c) The recipient to be sterilized must not be institutionalized in a corrective, penal, mental, or rehabilitative facility.

(5) Physician services for sterilization must meet the following requirements in order to receive medicaid reimbursement:

(a) The recipient to be sterilized must give informed consent, in accordance with the medicaid approved informed consent to sterilization form, not less than 30 days nor more than 180 days prior to sterilization except in the case of premature delivery or emergency abdominal surgery. For these exceptions, at least 72 hours must pass between informed consent and the sterilization procedure. In cases of premature delivery, informed consent must be given at least 30 days before the expected delivery date.

(b) The recipient to be sterilized, the person who obtained the consent, and the interpreter (if required) must sign the informed consent form at least 30 days but not more than 180 days prior to the sterilization. The physician performing the sterilization must sign and date the informed consent form after the sterilization has been performed.

(c) A copy of the informed consent to sterilization form must be attached to the medicaid claim when billing for sterilization procedures.

(6) Coverage of physician services for hysterectomies is limited as follows:

(a) The surgery must not be solely for the purpose of rendering the recipient incapable of reproducing; and

(b) The surgery must be medically necessary to treat injury or pathology.

(7) Physician services for hysterectomies must meet the following requirements in order to receive medicaid reimbursement:

(a) The physician must inform the recipient that the hysterectomy will render her permanently incapable of reproducing;

(b) A completed copy of the approved acknowledgment of receipt of hysterectomy information form must be attached to the medicaid claim when billing for hysterectomy services;

(c) In a case where the recipient is sterile before the hysterectomy or there is a life-threatening emergency that precludes the recipient from giving prior acknowledgment of receipt of hysterectomy
(7) The requirements in (7)(a) and (7)(b) do not apply. Instead the physician who performed the hysterectomy either:

(i) must certify in writing that the recipient was sterile before the hysterectomy and state the cause of sterility; or

(ii) must certify in writing that the hysterectomy was performed during a life-threatening emergency situation that precluded the recipient from giving prior acknowledgment of receipt of hysterectomy information and gives a description of the nature of the emergency.

(8) Coverage of physician services for abortions is limited as follows:

(a) the life of the mother will be endangered if the fetus is carried to term; or

(b) the pregnancy is the result of an act of rape or incest.

(9) Physician services for abortions in a case of endangerment of the mother's life must meet the following requirements in order to receive medicaid reimbursement:

(a) The physician must find, and certify in writing, that in the physician's professional judgement, the life of the mother will be endangered if the fetus is carried to term. The certification must contain the name and address of the patient and must be on or attached to the medicaid claim.

(10) Physician services for abortions in cases of pregnancy resulting from an act of rape or incest must meet the following requirements in order to receive medicaid reimbursement:

(a) the recipient certifies in writing that the pregnancy resulted from an act of rape or incest; and

(b) the physician certifies in writing either that:

(i) the recipient has stated to the physician that she reported the rape or incest to a law enforcement or protective services agency having jurisdiction over the matter, or if the recipient is a child enrolled in a school, to a school counselor; or

(ii) in the physician's professional opinion, the recipient was and is unable for physical or psychological reasons to report the act of rape or

(11) Physician services for routine podiatric care and orthotics must be in accord with the definitions of ARM 37.86.501 and meet the requirements of ARM 37.86.505.

ARM 37.106.301

ADMINISTRATIVE RULES OF MONTANA
TITLE 37. DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES
CHAPTER 106. HEALTH CARE FACILITIES
SUBCHAPTER 3. CONSTRUCTION AND
MINIMUM STANDARDS FOR ALL HEALTH
CARE
FACILITIES
Current through June 30, 2005

37.106.301. DEFINITIONS

The following definitions apply in this subchapter:

(1) "Administrator" means the individual responsible for the day-to-day operation of a hospital, skilled or intermediate care facility. This individual may also be known as, but not limited to, "chief executive officer", "executive director", or "president".

(2) "Adult day care center" means a facility as defined in § 50-5-101(2), MCA, but does not include day habilitation programs for the developmentally disabled and handicapped or a program offered by a church or senior citizens organization for purposes other than provision of custodial care necessary to meet daily living needs.

(3) "Communicable disease" means an illness due or suspected to be due to a specific infectious agent or its toxic products, which results from transmission of that agent or its products to a susceptible host directly or indirectly, and includes a dangerous communicable disease.

(4) "Coronary care unit" means an area within the hospital where there is a concentration of physicians, nurses, and other staff who have special skills and experience in providing care for critically ill cardiac patients.

(5) "Diagnostic" means the art, science or method of distinguishing signs or symptoms of a diseased condition.

(6) "Hospitalization" means being hospitalized or admitted to a hospital.

(7) "Hospital record" means written records of admissions, discharges, total patient days, register of operations performed and outpatients treated.

(8) "Inpatient" means a patient lodged and fed in a facility while receiving treatment.

(9) "Intensive care unit" means an area within the hospital where there is a concentration of physicians, nurses, and other staff who have specialized skills and experience in providing care for critically ill medical and surgical patients.

(10) "Manager" means the individual responsible for the day-to-day operation of a health care facility, excluding a hospital, skilled or intermediate care facility.

(11) "Medical record" means a written document which is complete, current and contains sufficient information for planning a patient's or resident's care, reviewing and evaluating care rendered, evaluating a patient's or resident's condition, and for providing a means of communication among all persons providing care.

(12) "Obstetrical service" means an area within the hospital which provides care for a maternity patient including but not limited to labor, delivery and postpartum care.

(13) "Outpatient" means a person receiving health care services and treatment at a facility without being admitted as an inpatient to the facility.

(14) "Supervise" means to oversee and direct staff by being present in the health care facility.


ARM 37.106.301

END OF DOCUMENT
37.106.314. MINIMUM STANDARDS FOR ALL HEALTH CARE FACILITIES: MEDICAL RECORDS

(1) A health care facility shall initiate and maintain by storing in a safe manner and in a safe location a medical record for each patient and resident.

(2) A health care facility, excluding a hospital, shall retain a patient's or resident's medical records for no less than five years following the date of the patient's or resident's discharge or death.

(3) A medical record may be microfilmed or preserved via any other electronic medium that yields a true copy of the record if the health care facility has the equipment to reproduce records on the premises.

(4) A signature of a physician may not be stamped on a medical record unless there is a statement in the facility administrator's or manager's file signed by the physician stating that the physician is responsible for the content of any document signed with his rubber stamp.

(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 50-5-106, 50-5-204 and 50-5-404, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; AMD, 1990 MAR p. 1259, Eff. 6/29/90; TRANS, from DHES, 2002 MAR p. 185.)
ARM 37.106.402

ARM 37.106.402

ADMINISTRATIVE RULES OF MONTANA
TITLE 37. DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES
CHAPTER 106. HEALTH CARE FACILITIES
SUBCHAPTER 4. MINIMUM STANDARDS
FOR A HOSPITAL
Current through June 30, 2005

37.106.402. MINIMUM STANDARDS FOR A
HOSPITAL: MEDICAL RECORDS

Medical records shall comply with the following
requirements:

(1) A patient's entire medical record must be
maintained, in either its original form or that allowed
by ARM 37.106.314(3), for not less than 10 years
following the date of a patient's discharge or death,
or, in the case of a patient who is a minor, for not less
than 10 years following the date the patient either
attains the age of majority or dies, if earlier.

(2) An obstetrical record shall be developed for each
maternity patient and must include the prenatal
record, labor notes, obstetrical anesthesia notes and
delivery record.

(3) A record must be developed for each newborn,
and shall include, in addition to the information in
(2), the following information:

   (a) observations of newborn after birth;
   (b) delivery room care of newborn;
   (c) physical examinations performed on newborn;
   (d) temperature of newborn;
   (e) weight of newborn;
   (f) time of newborn's first urination;
   (g) number, character and consistency of newborn's
       stool;
   (h) type of feeding administered to newborn;
   (i) phenylketonuria report for newborn;
   (j) name of person to whom newborn is released.

(4) A patient's entire medical record may be abridged
following the dates established in (1) to form a core
medical record of the patient's medical record. The
core medical record or the microfilmed medical
record should be maintained permanently but must be
maintained not less than 10 years beyond the periods
provided in (1). A core record shall contain at a
minimum the following information:

   (a) identification of patient data which includes
       name, maiden name if relevant, address, date of birth,
       sex, and, if available, social security number;
   (b) medical history;
   (c) physical examination report;
   (d) consultation reports;
   (e) report of operation;
   (f) pathology report;
   (g) discharge summary, except that for newborns and
       others for whom no discharge summary is available,
       the final progress note must be retained;
   (h) autopsy findings;
   (i) for each maternity patient, the information
       required by (2); and
   (j) for each newborn, the information required by
       (3).

(5) Nothing in this rule may be construed to prohibit
retention of hospital medical records beyond the
period described herein or to prohibit the retention of
the entire medical record.

(6) Diagnostic imaging film and electrodiagnostic
tracings must be retained for a period of five years;
their interpretations must be retained for the same
periods required for the medical record in (1), but
need not be retained beyond those periods.

(History: Sec. 50-5-103 and 50-5-404, MCA; IMP,
Sec. 50-5-103, 50-5-106 and 50-5-404, MCA; NEW,
1980 MAR p. 1587, Eff. 6/13/80; AMD, 1986 MAR
6/29/90; TRANS, from DHES, 2002 MAR p. 185.)

ARM 37.106.402

END OF DOCUMENT

ARM 37.106.405

ARM 37.106.405

ADMINISTRATIVE RULES OF MONTANA
TITLE 37. DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
CHAPTER 106. HEALTH CARE FACILITIES
SUBCHAPTER 4. MINIMUM STANDARDS FOR A HOSPITAL
Current through June 30, 2005

37.106.405. MINIMUM STANDARDS FOR A HOSPITAL: ORGAN DONATION REQUESTS AND PROTOCOLS

(1) This rule is adopted to implement Chapter 219, Laws of 1987, which amended both the Uniform Anatomical Gift Act, Title 72, chapter 17, MCA, and the Montana Health Care Facility Licensing Act, Title 50, chapter 5, part 2, MCA. Sections (2) through (5) of this rule paraphrase 72-17-211, MCA of the Uniform Anatomical Gift Act and are included here to clarify the requirements for hospitals in cases of patients who are suitable organ donors. For a full text of the Uniform Anatomical Gift Act, reference should be made to Title 72, chapter 17, MCA.

(2) When, according to generally accepted medical standards, a patient is a suitable candidate for donation of body parts as defined in 72-17-102(8), MCA, the hospital administrator or his/her designated representative shall communicate to the next-of-kin (as defined in (3) below) the option of donating all or any part of the patient's body and of the next-of-kin's option to decline. In addition to communicating such options, the hospital administrator or his/her designee must also request the next-of-kin to consent to an anatomical gift. The foregoing obligations of the administrator must be carried out unless the administrator or his/her designee:

(a) has actual notice of opposition to the gift by the decedent or the next-of-kin as defined in (3) below; or

(b) has reason to believe that an anatomical gift is contrary to the decedent's religious beliefs; or

(c) is aware of medical or emotional conditions under which the request would contribute to severe emotional distress.

(3) "Next-of-kin" as provided in 72-17-201(2), MCA, means one of the following persons in order of priority listed:

(a) the spouse;

(b) an adult son or daughter;

(c) either parent;

(d) an adult brother or sister; and

(e) a guardian of the person of the decedent at the time of death.

(4) The medical record of each patient who dies in a hospital and who is determined (under the hospital's protocol established under (6) below) to be a suitable candidate for donation of body parts must contain an entry setting forth the following:

(a) the name and affiliation of the individual who communicated the option to donate to the next-of-kin and who made the request for anatomical gift under (1) above;

(b) the name, relationship to the patient, and response of the individual to whom the option to donate was communicated and of whom the request for anatomical gift was made; and

(c) if no communication of an option or if no request for anatomical gift was made, the reason why no such request was made.

(5) An anatomical gift by a next-of-kin may be made in writing or by telegraphic, recorded telephonic, or other recorded message.

(6) By November 1, 1987, every hospital shall establish and have on file a written protocol that:

(a) assures identification of potential organ and tissue donors;

(b) assures that next-of-kin of patients who are suitable candidates for donation of body parts are made aware of their option to make an anatomical gift and are requested to consent to an anatomical gift of all or any part of the patient's body, unless one of the exceptions in (2)(a), (2)(b) or (2)(c) applies;

(c) encourages discretion and sensitivity with respect to the circumstances, views, and beliefs of families of potential organ donors; and

(d) provides for notification of an appropriate federally approved organ procurement organization when potential organ donors are identified in the hospital.

(7) Upon request, every hospital must make its adopted written protocol available to department personnel for their review.

(8) The protocol must, at a minimum, in addition to the items in (6) above, address and provide for the following aspects of an organ donation notification/request/referral program:

(a) method(s) by which the public is notified that the hospital has an organ procurement program;

(b) determination of medical suitability of potential donors of body parts, including consideration of factors such as donor age, previous disease history, and presence of infection; and documentation of non-suitability of patients initially identified as potential donors;

(c) a training and educational program conducted on a yearly basis in conjunction with a procurement organization (or the equivalent) to instruct appropriate hospital staff or others to convey organ donation information to next-of-kin and to make requests from next-of-kin, which program consists of formal training, seminars, in-service workshops, or other training (or a combination thereof) leading to a knowledge of and familiarity with the following:

(i) general historical, medical, legal and social concepts involved in organ donation and transplantation;

(ii) psychological and emotional considerations when dealing with bereaved families;

(iii) religious, cultural, and ethical considerations associated with organ donation;

(iv) procedures for approaching donors and/or donors’ next-of-kin, including physician notification, timing and location of contact, content(s) of communication concerning donor cards, consent forms, donation costs (if any), and actual requests for donation;

(d) orientation and instruction on a yearly basis in conjunction with a procurement organization (or the equivalent) in the respective disciplines of hospital staff and/or other personnel who will or may be participating in the hospital’s organ procurement program, such as chief of staff, attending physicians, nursing staff, social workers, clergy, or a team combining any of such persons; and

(e) the following forms to be used by the hospital to document that next-of-kin of medically suitable patients have been notified of the option to consent to an anatomical gift and have been requested to authorize such donation(s) as required in (2) above (and, if any such contact has not been made, the reason(s) why not):

(i) patient authorization;

(ii) consent of next-of-kin; and

(iii) notification of organ procurement organization(s).

(9) The hospital administrator shall designate a person or persons to represent him/her for the purpose of communicating to the next-of-kin the option of an anatomical gift and to make requests for anatomical gifts, in cases where the administrator is unable or will not be making such requests personally. Such persons shall receive the training specified in (8) above, and a list of such person(s) must be made available upon request to department personnel.

(10) A person who acts in good faith in accordance with the terms of (2) of this rule is not liable for damages in any civil proceeding or subject to prosecution in any criminal proceeding that might result from this action.

(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 50-5-204 and 50-5-404, MCA; NEW, 1987 MAR p. 1786, Eff. 10/16/87; TRANS, from DHES, 2002 MAR p. 185.)

ARM 37.106.405

END OF DOCUMENT
ARM 37.106.1001

ARM 37.106.1001

ADMINISTRATIVE RULES OF MONTANA
TITLE 37. DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES
CHAPTER 106. HEALTH CARE FACILITIES
SUBCHAPTER 10. MINIMUM STANDARDS
FOR OUTPATIENT FACILITIES
Current through June 30, 2005

37.106.1001. MINIMUM STANDARDS FOR AN OUTPATIENT FACILITY

(1) Nursing services must be provided by or under the supervision of a licensed registered nurse.

(2) Standing orders utilized for emergency or postoperative care shall be recorded in each patient's medical record and dated and signed by his licensed physician.

(3) An outpatient facility shall maintain a medical record for each patient which includes, but is not limited to, the following information:

(a) identification data;
(b) chief complaint;
(c) present illness;
(d) medical history;
(e) physical examination;
(f) laboratory and x-ray reports;
(g) treatment administered;
(h) tissue report;
(i) progress reports;
(j) discharge summary.

(History: Sec. 50-5-103 and 50-5-404, MCA; IMP, Sec. 50-5-103, 50-5-204 and 50-5-404, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; TRANS, from DHES, 2002 MAR p. 185.)

ARM 37.106.1001

END OF DOCUMENT
37.106.2902. DEFINITIONS

The following definitions, in addition to those contained in 50-5-1202, MCA, apply to this chapter:

(1) "Assistive device" means any device whose primary purpose is to maximize the independence and the maintenance of health of an individual who is limited by physical injury or illness, psychosocial dysfunction, mental illness, developmental or learning disability, the aging process, cognitive impairment or an adverse environmental condition. If the device is primarily used to restrict an individual's movement, it is considered a safety device or restraint rather than an assistive device.

(2) "Licensed health care professional" means a physician, a physician assistant-certified, a nurse practitioner or a registered or practical nurse licensed in the state of Montana.

(3) "Medical symptom", as defined in 50-5-1202, MCA, means an indication of a physical or psychological condition or of a physical or psychological need expressed by the patient. For example, a concern for the resident's physical safety by any person listed in 50-5-1201(1), MCA, or a resident's fear of falling may constitute a medical symptom.

(4) "Postural support" means an appliance or device used to achieve proper body position and balance, to improve a resident's mobility and independent functioning, or to position rather than restrict movement, including, but not limited to, preventing a resident from falling out of a bed or chair. A postural support does not include tying a resident's hands or feet or otherwise depriving a resident of their use.

(5) "Restraint" means any method (chemical or physical) of restricting a person's freedom of movement that prevents them from independent and purposeful functioning. This includes seclusion, controlling physical activity, or restricting normal access to the resident's body that is not a usual and customary part of a medical diagnostic or treatment procedure to which the resident or the authorized representative has consented.

(6) "Safety devices", as defined in 50-5-1202, MCA, means side rails, tray tables, seat belts and other similar devices. The department interprets that definition to mean that a safety device is used to maximize the independence and the maintenance of health and safety of an individual by reducing the risk of falls and injuries associated with the resident's medical symptom.

(History: Sec. 50-5-103, 50-5-226, 50-5-227 and 50-5-1205, MCA; IMP, Sec. 50-5-103, 50-5-226, 50-5-227, 50-5-1202 and 50-5-1203, MCA; NEW, 2002 MAR p. 3159, Eff. 11/15/02.)

END OF DOCUMENT
ADMINISTRATIVE RULES OF MONTANA
TITLE 37. DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES
CHAPTER 106. HEALTH CARE FACILITIES
SUBCHAPTER 29. RESTRAINTS, SAFETY
DEVICES, ASSISTIVE DEVICES, AND
POSTURAL
SUPPORTS
Current through June 30, 2005

Rule 03. RESERVED

END OF DOCUMENT
37.106.2904. USE OF RESTRAINTS, SAFETY DEVICES, ASSISTIVE DEVICES, AND POSTURAL SUPPORTS

(1) The application or use of a restraint, safety device or postural support is prohibited except to treat a resident's medical symptoms and may not be imposed for purposes of coercion, retaliation, discipline or staff convenience.

(2) A restraint may be a safety device when requested by the resident or the resident's authorized representative or physician to reduce the risk of falls and injuries associated with a resident's medical symptoms and used in accordance with 50-5-1201, MCA.

(3) To the extent that a resident needs emergency care, restraints may be used for brief periods:

(a) to permit medical treatment to proceed unless the health care facility has been notified that the resident has previously made a valid refusal of the treatment in question; or

(b) if a resident's unanticipated violent or aggressive behavior places the resident or others in imminent danger, in which case the resident does not have the right to refuse the use of restraints. In this situation:

(i) the use of restraints is a measure of last resort to protect the safety of the resident or others and may be used only if the facility determines and documents that less restrictive means have failed;

(ii) the size, gender, physical, medical and psychological condition of the resident must be considered prior to the use of a restraint;

(iii) a licensed nurse shall contact a resident's physician for restraint orders within one hour of application of a restraint;

(iv) the licensed nurse shall document in the resident's clinical record the circumstances requiring the restraints and the duration; and

(v) a restrained resident must be monitored as their condition warrants, and restraints must be removed as soon as the need for emergency care has ceased and the resident's safety and the safety of others can be assured.

(4) In accordance with the Montana Long-Term Care Residents' Bill of Rights, the resident or authorized representative is allowed to exercise decision-making rights in all aspects of the resident's health care or other medical regimens, with the exception of the circumstances described in (3)(b).

(5) Single or two quarter bed rails that extend the entire length of the bed are prohibited from use as a safety or assistive device; however, a bed rail that extends from the head to half the length of the bed and used primarily as a safety or assistive device is allowed.

(6) Physician-prescribed orthopedic devices used as postural supports are not considered safety devices or restraints and are not subject to the requirements for safety devices and restraints contained in these rules.

(7) Whenever a restraint, safety device, or postural support is used that restricts or prevents a resident from independent and purposeful functioning, the resident must be provided the opportunity for exercise and elimination needs at least every two hours, or more often as needed, except when a resident is sleeping.

(8) All methods of restraint, safety devices, assistive devices and postural supports must be properly fastened or applied in accordance with manufacturer's instructions and in a manner that permits rapid removal by the staff in the event of fire or other emergency.

(History: Sec. 50-5-103, 50-5-226, 50-5-227 and 50-5-1205, MCA; IMP, Sec. 50-5-103, 50-5-226, 50-5-227, 50-5-1201, 50-5-1202 and 50-5-1204, MCA; NEW, 2002 MAR p. 3159, Eff. 11/15/02.)
37.106.2905. DOCUMENTATION IN RESIDENT'S MEDICAL RECORDS

(1) Prior to the use of a restraint or safety device, the following items must be included in the resident's record:

(a) a consent form signed by the resident or authorized representative that includes documentation that:

(i) the resident or the resident's authorized representative was given a written explanation of the alternatives and any known risks associated with the use of the restraint or safety device;

(ii) cites any pre-existing condition that may place a patient at risk of injury; and

(b) written authorization from the resident's primary physician that specifies the medical symptom that the restraint or safety device is intended to address and the type of circumstances and duration under which the restraint or safety device is to be used.

(2) When a restraint or safety device is used, the following items must be documented in the resident's record:

(a) frequency of monitoring in accordance with documented facility policy;

(b) assessment and provision of treatment if necessary for skin care, circulation and range of motion; and

(c) any unusual occurrences or problems.

(3) During a quarterly re-evaluation, a facility must consider:

(a) using the least restrictive restraint or safety device to restore the resident to a maximum level of functioning;

(b) causes for the medical symptoms that led to the use of the restraint or safety device; and

(c) alternative safety measures if a restraint or safety device is removed. Before removing a restraint or safety device, the resident or the authorized representative and the attending physician must be consulted.

(History: Sec. 50-5-103, 50-5-226, 50-5-227 and 50-5-1205, MCA; IMP, Sec. 50-5-103, 50-5-226, 50-5-227, 50-5-1201, 50-5-1203 and 50-5-1204, MCA; NEW, 2002 MAR p. 3159, Eff. 11/15/02.)
37.114.101. DEFINITIONS

Unless otherwise indicated, the following definitions apply throughout this chapter:

(1) "Blood and body fluid precautions" mean the following requirements to prevent spread of disease through contact with infective blood or body fluids:

(a) If soiling with blood or body fluids is likely, gowns must be used to cover clothes, worn only once, and laundered.

(b) Single-use gloves must be used if blood or body fluids, mucous membranes, or non-intact skin will be touched, items or surfaces soiled with blood or body fluids handled, and for performing vascular access procedures other than venipuncture; the gloves must be changed before touching another person and discarded in a manner preventing contact with them thereafter. (It is recommended, though not required, that single-use gloves coupled with proper aseptic procedures also be used for performing venipuncture.)

(c) Hands must be washed immediately after gloves are removed or if they are potentially contaminated with blood or body fluids and before touching another person.

(d) Articles contaminated with blood or body fluids must be discarded or disinfected.

(e) Injuries from needles or other sharp devices must be avoided; used needles must not be recapped, bent, or broken by hand, removed from disposable syringes, or otherwise manipulated by hand; after use, disposable syringes and needles, scalpel blades, and other sharp items must be placed in a prominently labeled, puncture-resistant container for disposal, located as closely as practicable to the use area; large-bore reusable needles must be placed in such a container for transport to the reprocessing area.

(f) If a needle-stick injury occurs, the injured person must be evaluated immediately to determine if hepatitis prophylaxis is needed or human immunodeficiency virus is a concern.

(g) Any blood spills must be cleaned up promptly with a solution of 5.25% sodium hypochlorite (for example, regular chlorox or purex bleach) diluted 1:10 with water.

(h) A case must be restricted to a private room if the case's hygiene is poor, i.e., the case does not wash hands after touching infective material, contaminates the environment with infective material, or shares contaminated articles with other individuals who as yet have not contracted the disease in question; such a person may share a room with anyone else infected with the same organism.

(i) Masks and protective eyewear or face shields must be worn during procedures that are likely to generate droplets of blood or other body fluids.

(j) In areas where resuscitation is likely to be practiced (e.g. emergency rooms), mouthpieces, resuscitation bags, or other ventilation devices must be available.

(k) No one who has an exudative lesion or weeping dermatitis in an area likely to be touched may directly care for a patient or handle patient-care equipment.

(2) "Carrier" means a person or animal who harbors a specific infectious agent without discernible illness and serves as a potential source of infection. A carrier may be "incubatory" (just before onset), "convalescent" (after clinical recovery), or "healthy" (no apparent illness at any time). The carrier state may be temporary or permanent.

(3) "Case" means a person who is confirmed or suspected to have a reportable disease or condition.

(4) "Clean" means to remove from surfaces, by scrubbing and washing, as with hot water and soap or detergent, infectious agents and organic matter on which and in which infectious agents may be able to live and remain virulent.

(5) "Communicable disease" means an illness due or suspected to be due to a specific infectious agent or its toxic products, which results from transmission of that agent or its products to a susceptible host, directly or indirectly.
(6) "Concurrent disinfection" means the use of a method which will destroy any harmful infectious agents present immediately after the discharge of infectious material from the body of an infected person, or after the soiling of articles with such infectious discharges before there is opportunity for any other contact with them.

(7) "Contact" means a person or animal that has had opportunity to acquire an infection due to its association with an infected person or animal or a contaminated environment.

(8) "Contamination" means the presence of a disease-causing agent upon a living body surface or within or upon any inanimate article or substance.

(9) "Department" means the department of public health and human services.

(10) "Drainage and secretion precautions" mean the following requirements to prevent spread of disease through contact with purulent material from an infected body site:

(a) If soiling by the infective material is likely, gowns must be worn, used only once, and laundered.

(b) Single-use gloves must be used if infective material will be touched, and discarded in a manner preventing contact with them thereafter.

(c) Anyone touching the case or potentially contaminated articles must wash their hands immediately afterward and before touching another person.

(d) Any article contaminated with infective material must be discarded or disinfected in a manner which prevents contact with the material thereafter.

(11) "Enteric precautions" mean the following requirements to prevent spread of disease through feces:

(a) Gowns must be used to cover clothes if soiling is likely, worn only once, and laundered.

(b) Single-use gloves must be used if infective material will be touched, and discarded in a manner preventing contact with them thereafter.

(c) Hands must be washed after touching the case or potentially contaminated articles and before touching another person.

(d) Articles contaminated with infective material must be either thoroughly disinfected before they are removed from the infected person's room, or bagged, labeled, and burned or decontaminated.

(e) A case must be restricted to a private room if the case's hygiene is poor, i.e., the case does not wash hands after touching infective material, contaminates the environment with infective material, or shares contaminated articles with other individuals who as yet have not contracted the disease in question; such a person may share a room with anyone else infected with the same organism.

(12) "Health care" means health care as defined in 50-16-504, MCA.

(13) "Health care facility" is a facility defined in 50-5-101, MCA.

(14) "Health care provider" means a health care provider as defined in 50-16-504, MCA.

(15) "HIV infection" means infection with the human immunodeficiency virus.

(16) "Household contact" is a person or animal living within the household of an infected person.

(17) "Infected person" means a person who harbors an infectious agent and who has either manifest disease or inapparent infection.

(18) "Infection" means the entry and development or multiplication of an infectious agent in the body of man or animals. Infection is not synonymous with infectious disease; the result may be inapparent or manifest. The presence of living infectious agents on the exterior surface of the body or upon articles of apparel or soiled articles is not infection, but contamination of such surfaces and articles.

(19) "Infectious agent" means an organism, chiefly a microorganism, but including helminths, that is capable of producing an infection or infectious disease.

(20) "Infectious disease" means a clinically manifest disease of man or animals resulting from an infection.

(21) "Infectious person" means a person from whom another person may acquire an infectious agent by touch or proximity.
(22) "Isolation" means separation during the period of communicability of an infected or probably infected person from other persons, in places and under conditions approved by the department or local health officer and preventing the direct or indirect conveyance of the infectious agent to persons who are susceptible to the infectious agent in question or who may convey the infection to others. Isolation may be either modified or strict, as defined below:

(a) "Modified isolation" means instruction by either the department, a local health officer, or an attending physician, directed to the infected person, any members of that person's family, and any other close contacts, in accordance with "Guideline for Isolation Precautions in Hospitals" published by the government printing office, published in 1996, setting restrictions on the movements of and contacts with the infected person and specifying whichever of the following are also appropriate:

(i) tuberculosis isolation;
(ii) respiratory isolation;
(iii) enteric precautions;
(iv) drainage and secretion precautions;
(v) blood and body fluid precautions;

(b) "Strict isolation" includes the following measures:

(i) An infected person must be isolated behind a closed door in a separate bed in a room protected from potential vectors.

(ii) A person caring for an infected person must avoid coming into contact with any other person until every precaution required has been taken to prevent the spread of infectious material.

(iii) Each person caring for an infected person must wear a washable outer garment, mask, and gloves, and must thoroughly wash their own hands with soap and hot water after handling an infected person or an object an infected person may have contaminated. Before leaving the room of an infected person, a person caring for an infected person must remove the washable outer garment and hang it in the infected person's room until the garment and room are disinfected.

(iv) An object which may have been contaminated by an infected person must be either thoroughly disinfected before it is removed from the infected person's room or bagged, labeled, and burned or decontaminated.

(v) Disposal of feces and urine of an infected person must be made by flushing them down a toilet attached to a municipal or other sewage system approved by the department.

(23) "Laboratorian" means any person who supervises or works in a laboratory.

(24) "Outbreak" means an incidence of a disease or infection significantly exceeding the incidence normally observed in a population of people over a period of time specific to the disease or infection in question.

(25) "Physician" means a person licensed to practice medicine in any jurisdiction in the United States or Canada.

(26) "Potential outbreak" means the presence or suspected presence of a communicable disease in a population where the number of susceptible persons and the mode of transmission of the disease may cause further spread of that disease.

(27) "Quarantine" means those measures required by a local health officer or the department to prevent transmission of disease to or by those individuals who have been or are otherwise likely to be in contact with an individual with a communicable disease.

(28) "Reportable disease" means any disease, the occurrence or suspected occurrence of which is required by ARM 37.114.203 to be reported.

(29) "Respiratory isolation" means:

(a) the patient must be in a private room;

(b) any person in close contact with the patient must wear a mask;

(c) any person caring for the patient must thoroughly wash their hands after touching the patient or contaminated articles and before touching another person; and

(d) articles contaminated with infective material must be discarded or bagged, labeled for decontamination, and decontaminated.
(30) "Sensitive occupation" means employment in direct care of children, the elderly, or individuals who are otherwise at a high risk for disease or where disease spread could occur due to the nature of the work.

(31) "Sexually transmitted disease" means human immunodeficiency virus (HIV) infection, syphilis, gonorrhea, chancroid, lymphogranuloma venereum, granuloma inguinale, or chlamydial genital infections.

(32) "Surveillance" means scrutiny of all aspects of occurrence and spread of a disease that are pertinent to effective control.

(33) "Susceptible" means having insufficient resistance against a disease and consequently liable to contract the disease if exposed.

(34) "Tuberculosis isolation" means:

(a) the patient must be in a private room which has ventilation to the outside and away from an enclosed area;

(b) if the infective organism can be spread by cough, a mask must be worn by anyone entering the patient's room; if the organism can be spread by fluid, a gown and gloves must be worn;

(c) any person caring for the patient must wash their hands after touching the patient or potentially contaminated articles and before touching another person; and

(d) all potentially contaminated articles must be cleaned, disinfected, or discarded.

(35) The department hereby adopts and incorporates by reference the "Guideline for Isolation Precautions in Hospitals" published by the Government Printing Office in 1996, which specifies precautions that should be taken to prevent transmission of communicable diseases. A copy of the "Guideline" may be obtained from the National Technical Information Service, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161, phone: (703)487-4650. Any orders should refer to the publication number PB96138102 for the Guideline for Isolation Precautions in Hospitals (1996).

37.114.201. REPORTERS

(1) With the exception noted in (3) below, any person, including but not limited to a physician, dentist, nurse, medical examiner, other health care practitioner, administrator of a health care facility, public or private school administrator, or laboratorian who knows or has reason to believe that a case exists shall immediately report to the local health officer the information specified in ARM 37.114.205(1) through (2).

(2) A local health officer must submit to the department, on the schedule noted in ARM 37.114.204, the information specified in ARM 37.114.205 concerning each confirmed or suspected case of which the officer is informed.

(3) A state funded anonymous testing site for HIV infection is not subject to the reporting requirement in (1) with regard to HIV testing.


Mont.Admin.R. 37.114.201, MT ADC 37.114.201
MT ADC 37.114.201

ARM 37.114.201

END OF DOCUMENT
37.114.203. REPORTABLE DISEASES AND CONDITIONS

(1) The following communicable diseases and conditions are reportable:

(a) AIDS, as defined by the centers for disease control, or HIV infection, as determined by a positive result from a test approved by the federal food and drug administration for the detection of HIV, including but not limited to antibody, antigen, or HIV nucleic acid tests;

(b) Amebiasis;

(c) Anthrax;

(d) Botulism (including infant botulism);

(e) Brucellosis;

(f) Campylobacter enteritis;

(g) Chancroid;

(h) Chickenpox;

(i) Chlamydial genital infection;

(j) Cholera;

(k) Colorado tick fever;

(l) Cryptosporidiosis;

(m) Cytomegaloviral illness;

(n) Diarrheal disease outbreak;

(o) Diphtheria;

(p) Encephalitis;

(q) Escherichia coli 0157:H7 enteritis;

(r) Gastroenteritis outbreak;

(s) Giardiasis;

(t) Gonorrhea;

(u) Gonococcal ophthalmia neonatorum;

(v) Granuloma inguinale;

(w) Haemophilus influenzae B invasive disease (meningitis, epiglottitis, pneumonia, and septicemia);

(x) Hansen's disease (leprosy);

(y) Hantavirus pulmonary syndrome;

(z) Hemolytic uremic syndrome;

(aa) Hepatitis A, B (acute or chronic), or C (acute or chronic);

(ab) Kawasaki disease;

(ac) Influenza;

(ad) Lead poisoning (levels >= 10 micrograms per deciliter);

(ae) Legionellosis;

(af) Listeriosis;

(ag) Lyme disease;

(ah) Lymphogranuloma venereum;
(ai) Malaria;

(aj) Measles (rubeola);

(ak) Meningitis, bacterial or viral;

(al) Mumps;

(am) Ornithosis (psittacosis);

(an) Pertussis (whooping cough);

(ao) Plague;

(ap) Poliomyelitis, paralytic or non-paralytic;

(aq) Q-fever;

(ar) Rabies or rabies exposure (human);

(as) Reye's syndrome;

(at) Rocky Mountain spotted fever;

(au) Rubella (including congenital);

(av) Salmonellosis;

(aw) Severe acute respiratory syndrome (SARS);

(ax) Shigellosis;

/ay) Smallpox;

(az) Streptococcus pneumoniae invasive disease, drug resistant;

(ba) Syphilis;

(bb) Tetanus;

(bc) Tickborne relapsing fever;

(bd) Transmissible spongiform encephalopathies;

(be) Trichinosis;

(bf) Tuberculosis;

(bg) Tularemia;

(bh) Typhoid fever;

(bi) Yellow fever;

(bj) Yersiniosis;

(bk) Illness occurring in a traveler from a foreign country;

(bl) An occurrence in a community or region of a case or cases of any communicable disease in the “Control of Communicable Diseases Manual, An Official Report of the American Public Health Association”, (18th edition, 2004), 2000, with a frequency in excess of normal expectancy; and

(bm) Any unusual incident of unexplained illness or death in a human or animal.


Mont ADMIN R. 37.114.203, MT ADC 37.114.203
MT ADC 37.114.203

END OF DOCUMENT
37.114.204. REPORTS AND REPORT DEADLINES

(1) A county, city-county, or district health officer or the officer's authorized representative must immediately report to the department by telephone the information cited in ARM 37.114.205(1) whenever a case of one of the following diseases is suspected or confirmed:

(a) Anthrax;
(b) Botulism (including infant botulism);
(c) Diphtheria;
(d) Measles (rubeola);
(e) Plague;
(f) Rabies or rabies exposure (human);
(g) Typhoid fever; or
(h) Any unusual incident of unexplained illness or death in a human or animal.

(2) A county, city-county, or district health officer or the officer's authorized representative must mail to the department the information required by ARM 37.114.205(1) for each suspected or confirmed case of one of the following diseases, within the time limit noted for each:

(a) On the same day information about a case of one of the following diseases is received by the county, city-county, or district health officer:

(i) Chancroid;
(ii) Cholera
(iii) Diarrheal disease outbreak;
(iv) Escherichia coli 0157:H7 enteritis;
(v) Gastroenteritis outbreak;
(vi) Gonorrhea;
(vii) Gonococcal ophthalmia neonatorum;
(viii) Granuloma inguinale;
(ix) Haemophilus influenzae B invasive disease (meningitis, epiglottitis, pneumonia, and septicemia);
(x) Hantavirus pulmonary syndrome;
(xi) Hemolytic uremic syndrome;
(xii) Listeriosis;
(xiii) Lymphogranuloma venereum;
(xiv) Meningitis, bacterial or viral;
(xv) Pertussis (whooping cough);
(xvi) Poliomyelitis, paralytic or non-paralytic;
(xvii) Rubella (including congenital);
(xviii) Syphilis;
(xix) Tetanus;
(xx) Yellow fever;
(xxî) Illness occurring in a traveler from a foreign country; and

(b) Within seven calendar days after the date information about a case of one of the following diseases is received by the county, city-county, or district health officer:

(i) Amebiasis;
(ii) Brucellosis;
(iii) Campylobacter enteritis;
(iv) Chlamydial genital infection;
(v) Cryptosporidiosis;
(vi) Cytomegaloviral illness;
(vii) Encephalitis;
(viii) Giardiasis;
(ix) Hansen's disease (leprosy);
(x) Hepatitis, A, B, or non-A non-B;
(xi) Kawasaki disease;
(xii) Lead poisoning (levels >= 10 micrograms per deciliter);
(xiii) Legionellosis;
(xiv) Lyme disease;
(xv) Malaria;
(xvi) Mumps;
(xvii) Ornithosis (Psittacosis);
(xviii) Q-fever;
(xix) Reye's syndrome;
(xx) Rocky Mountain spotted fever;
(xxi) Salmonellosis;
(xxii) Shigellosis;
(xxiii) Streptococcus pneumoniae invasive disease, drug resistant;
(xxiv) Trichinosis;
(xxv) Tuberculosis;
(xxvi) Tularemia; or
(xxvii) Yersiniosis.

(3) By Friday of each week during which a suspected or confirmed case of one of the diseases listed below is reported to the county, city-county, or district health officer, that officer or the officer's authorized representative must mail to the department the total number of the cases of each such disease reported that week:

(a) Colorado tick fever; and
(b) Influenza.

(4) Whenever a laboratory performs a blood lead analysis, a laboratorian employed at that laboratory must submit to the department, by the 15th day following the month in which the test was performed, a copy of all blood lead analyses performed that month, including analyses in which lead was undetectable.

(5) A laboratorian must submit to the department by the 15th day following each month a report on a form supplied by the department indicating the number of tests with negative or positive results which were done that month for tuberculosis or a sexually transmitted disease.


ARM 37.114.204

END OF DOCUMENT
37.114.205. REPORT CONTENTS

1) A report of a case of reportable disease or a condition which is required by ARM 37.114.204(1) or (2) must include, if available:

   (a) name and age of the case;

   (b) dates of onset of the disease or condition and the date the disease or condition was reported to the health officer;

   (c) whether or not the case is suspected or confirmed;

   (d) name and address of the case's physician; and

   (e) name of the reporter or other person the department can contact for further information regarding the case.

2) The information required by (1) must be supplemented by any other information in the possession of the reporter which the department requests and which is related to case management and/or investigation of the case.

3) The laboratory reports required by ARM 37.114.204(5) and the numerical report required by ARM 37.114.204(3) need contain only the information specified in those sections.

4) The name of any case with a reportable disease or condition and the name and address of the reporter of any such case are confidential and not open to public inspection:

37.114.503. ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) AND HIV INFECTION

(1) Whenever human immunodeficiency virus (HIV) infection occurs, infection control fluid precautions must be used for the duration of the infection.

(2) If a test confirms HIV infection, the department will contact the health care provider submitting the test or another health care provider designated by the subject of the test in order to determine whether acquired immune deficiency syndrome is present. If AIDS exists, the provider must submit a report pursuant to ARM 37.114.205.

(3) Either a health care provider treating an individual with HIV infection for that infection or a representative of the department or local health department must:

   (a) instruct the case how to prevent spreading the HIV infection to others;

   (b) provide the case with information about any available services relevant to the case's health status and refer the case to appropriate services;

   (c) interview the infected person to determine the person's contacts; and

   (d) locate each contact, counsel each contact, advise the contact to receive testing to determine the contact's HIV status, and refer the contact for appropriate services.

(4) The health care provider must either conduct the interview with the case and assist the case with contact notification or request the department to assist in conducting the interview and/or notifying contacts.

37.116.102. DEATH OF A PERSON WITH AN INFECTIOUS DISEASE AND NOTIFICATION OF MORTUARY

(1) When a person dies, the person's health care provider, the local coroner who certifies the death, or, if the death occurs in a health care facility, a facility staff member designated by the facility must notify the mortuary receiving the person's body, at the time of transfer of the body to the mortuary or as soon after transfer as possible, whether or not the person had or was suspected of having an infectious disease at the time of death. If the person did have or was suspected of having an infectious disease, the notice must also include what infectious disease the deceased individual had at the time of death and the nature of the disease. A sample form is available from the department's communicable disease control and prevention bureau, which may be used to provide the notice in writing to a mortuary.

(2) If a person has or is suspected by the person's health care provider or the coroner of having an infectious disease at the time of death, the local health officer, immediately after receiving notification of the infectious disease, must inform the mortician or any other person handling the body (before or after death) of that fact and of the appropriate measures which should be taken to prevent transmission.

(3) As soon as reasonably possible following death or the conclusion of further examination required to determine the cause of death, the body of a person who had or is suspected by the person's health care provider, the coroner, or the local health officer of having a viral hemorrhagic fever (lassa, ebola, Marburg, Congo-Crimean) or any other undiagnosable febrile disease occurring shortly after returning from international travel must be placed in a hermetically sealed bag or alternative container, handled only to the extent necessary, and either cremated subject to the restriction in 37-19-705(2), MCA, or buried immediately, unless an exception is granted pursuant to ARM 37.116.105

(4) Whether or not the mortuary receives notice that a deceased person had an infectious disease, blood and body fluid precautions as defined in ARM 37.114.101 must be taken by the mortuary staff in order to prevent transmission of any potential infectious disease to mortuary personnel.

(5) The definitions in ARM 37.114.101 apply to this chapter. A copy of ARM 37.114.101 may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, Communicable Disease Control and Prevention Bureau, Cogswell Building, P.O. Box 202951, Helena, MT 59620-2951.

37.116.103. TRANSPORTATION OF DEAD HUMAN BODIES

(1) The body of a person who died or is suspected by the person's health care provider, the coroner, or the local health officer of dying with a disease listed in ARM 37.116.102(3) may not be transported unless enclosed in a hermetically sealed casket or alternative container and the plans for transporting the container are approved by the local health officer.

(2) The body of a person who, at the time of death, did not have a disease listed in ARM 37.116.102(3):

(a) when removed from the place of death to a mortuary, must be transported by removal cot, transport stretcher or alternative container;

(b) must be placed in a casket or alternative container in order to be transported by common carrier. If such body is en route more than eight hours, or if the termination of common carrier transport occurs more than 36 hours after the time of death, the body must be either embalmed or refrigerated at 35° F or colder, so as to prevent or substantially retard decomposition and the resultant effluents and odors;

(c) when being transported by a private conveyer and the body will not reach its destination within 48 hours after the time of death, must be either embalmed or refrigerated at 35° F or colder, so as to prevent or substantially retard decomposition and the resultant effluents and odors.

(History: Sec. 50-1-202, MCA; IMP, Sec. 50-1-202, MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80; AMD, 1995 MAR p. 850, Eff. 5/12/95; TRANS & AMD, from DHES, 1999 MAR p. 345, Eff. 2/26/99.)
§ 606.170 Adverse reaction file.

(a) Records shall be maintained of any reports of complaints of adverse reactions regarding each unit of blood or blood product arising as a result of blood collection or transfusion. A thorough investigation of each reported adverse reaction shall be made. A written report of the investigation of adverse reactions, including conclusions and followup, shall be prepared and maintained as part of the record for that lot or unit of final product by the collecting or transfusing facility. When it is determined that the product was at fault in causing a transfusion reaction, copies of all such written reports shall be forwarded to and maintained by the manufacturer or collecting facility.

(b) When a complication of blood collection or transfusion is confirmed to be fatal, the Director, Office of Compliance and Biologics Quality, Center for Biologics Evaluation and Research, shall be notified by telephone, facsimile, express mail, or electronically transmitted mail as soon as possible; a written report of the investigation shall be submitted to the Director, Office of Compliance and Biologics Quality, Center for Biologics Evaluation and Research, within 7 days after the fatality by the collecting facility in the event of a donor reaction, or by the facility that performed the compatibility tests in the event of a transfusion reaction.

§ 549.60 Purpose and scope.

The Bureau of Prisons provides guidelines for the medical and administrative management of inmates who engage in hunger strikes. It is the responsibility of the Bureau of Prisons to monitor the health and welfare of individual inmates, and to ensure that procedures are pursued to preserve life.

[59 FR 31883, June 20, 1994]


28 C. F. R. § 549.60, 28 CFR § 549.60

Current through February 12, 2010; 75 FR 6995

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§ 549.61 Definition.

As defined in this rule, an inmate is on a hunger strike:

(a) When he or she communicates that fact to staff and is observed by staff to be refraining from eating for a period of time, ordinarily in excess of 72 hours; or

(b) When staff observe the inmate to be refraining from eating for a period in excess of 72 hours. When staff consider it prudent to do so, a referral for medical evaluation may be made without waiting 72 hours.


28 C.F.R. § 549.61, 28 CFR § 549.61

Current through February 12, 2010; 75 FR 6995

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§ 549.62 Initial referral.

(a) Staff shall refer an inmate who is observed to be on a hunger strike to medical or mental health staff for evaluation and, when appropriate, for treatment.

(b) Medical staff ordinarily shall place the inmate in a medically appropriate locked room for close monitoring.

[59 FR 31883, June 20, 1994]


28 C. F. R. § 549.62, 28 CFR § 549.62

Current through February 12, 2010; 75 FR 6995

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§ 549.63 Initial medical evaluation and management.

(a) Medical staff shall ordinarily perform the following procedures upon initial referral of an inmate on a hunger strike:

1. Measure and record height and weight;
2. Take and record vital signs;
3. Urinalysis;
4. Psychological and/or psychiatric evaluation;
5. General medical evaluation;
6. Radiographs as clinically indicated;
7. Laboratory studies as clinically indicated.

(b) Medical staff shall take and record weight and vital signs at least once every 24 hours while the inmate is on a hunger strike. Other procedures identified in paragraph (a) of this section shall be repeated as medically indicated.

(c) When valid medical reasons exist, the physician may modify, discontinue, or expand any of the medical procedures described in paragraphs (a) and (b) of this section.

(d) When medical staff consider it medically mandatory, an inmate on a hunger strike will be transferred to a Medical Referral Center or to another Bureau institution considered medically appropriate, or to a community hospital.

[59 FR 31883, June 20, 1994]

SOURCE: 45 FR 23365, Apr. 4, 1980; 52 FR 48068,
§ 549.64 Food/liquid intake/output.

(a) Staff shall prepare and deliver to the inmate's room three meals per day or as otherwise authorized by the physician.

(b) Staff shall provide the inmate an adequate supply of drinking water. Other beverages shall also be offered.

(c) Staff shall remove any commissary food items and private food supplies of the inmate while the inmate is on a hunger strike. An inmate may not make commissary food purchases while under hunger strike management.

[59 FR 31883, June 20, 1994]


28 C. F. R. § 549.64, 28 CFR § 549.64

Current through February 12, 2010; 75 FR 6995

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Refusal to accept treatment.

(a) When, as a result of inadequate intake or abnormal output, a physician determines that the inmate's life or health will be threatened if treatment is not initiated immediately, the physician shall give consideration to forced medical treatment of the inmate.

(b) Prior to medical treatment being administered against the inmate's will, staff shall make reasonable efforts to convince the inmate to voluntarily accept treatment. Medical risks faced by the inmate if treatment is not accepted shall also be explained to the inmate. Staff shall document their treatment efforts in the medical record of the inmate.

(c) When, after reasonable efforts, or in an emergency preventing such efforts, a medical necessity for immediate treatment of a life or health threatening situation exists, the physician may order that treatment be administered without the consent of the inmate. Staff shall document their treatment efforts in the medical record of the inmate.

(d) Staff shall continue clinical and laboratory monitoring as necessary until the inmate's life or permanent health is no longer threatened.

(e) Staff shall continue medical, psychiatric and/or psychological follow-up as long as necessary.

[59 FR 31883, June 20, 1994]


AUTHORITY: 5 U.S.C. 301; 10 U.S.C. 876b; 18
§ 549.66 Release from treatment.

Only the physician may order that an inmate be released from hunger strike evaluation and treatment. This order shall be documented in the medical record of the inmate.

[59 FR 31883, June 20, 1994]


28 C.F.R. § 549.66, 28 CFR § 549.66

Current through February 12, 2010; 75 FR 6995

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END OF DOCUMENT
(a) Scope and Application. This section applies to all occupational exposure to blood or other potentially infectious materials as defined by paragraph (b) of this section.

(b) Definitions. For purposes of this section, the following shall apply:

Assistant Secretary means the Assistant Secretary of Labor for Occupational Safety and Health, or designated representative.

Blood means human blood, human blood components, and products made from human blood.

Bloodborne Pathogens means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

Clinical Laboratory means a workplace where diagnostic or other screening procedures are performed on blood or other potentially infectious materials.

Contaminated means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

Contaminated Laundry means laundry which has been soiled with blood or other potentially infectious materials or may contain sharps.

Contaminated Sharps means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

Decontamination means the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

Director means the Director of the National Institute for Occupational Safety and Health, U.S. Department of Health and Human Services, or designated representative.

Engineering controls means controls (e.g., sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needleless systems) that isolate or remove the bloodborne pathogens hazard from the workplace.

Exposure Incident means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

Handwashing Facilities means a facility providing an adequate supply of running potable water, soap and single use towels or hot air drying machines.

Licensed Healthcare Professional is a person whose legally permitted scope of practice allows him or her to independently perform the activities required by paragraph (f) Hepatitis B Vaccination and Post-exposure Evaluation and Follow-up.

HBV means hepatitis B virus.

HIV means human immunodeficiency virus.

Needleless systems means a device that does not use needles for:
(1) The collection of bodily fluids or withdrawal of body fluids after initial venous or arterial access is established;

(2) The administration of medication or fluids; or

(3) Any other procedure involving the potential for occupational exposure to bloodborne pathogens due to percutaneous injuries from contaminated sharps.

Occupational Exposure means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

Other Potentially Infectious Materials means

(1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids;

(2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and

(3) HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

Parenteral means piercing mucous membranes or the skin barrier through such events as needlesticks, human bites, cuts, and abrasions.

Personal Protective Equipment is specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment.

Production Facility means a facility engaged in industrial-scale, large-volume or high concentration production of HIV or HBV.

Regulated Waste means liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.

Research Laboratory means a laboratory producing or using research-laboratory-scale amounts of HIV or HBV. Research laboratories may produce high concentrations of HIV or HBV but not in the volume found in production facilities.

Sharps with engineered sharps injury protections means a nonneedle sharp or a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, with a built-in safety feature or mechanism that effectively reduces the risk of an exposure incident.

Source Individual means any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.

Sterilize means the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

Universal Precautions is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

Work Practice Controls means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique).

(c) Exposure control--

(1) Exposure Control Plan.
(i) Each employer having an employee(s) with occupational exposure as defined by paragraph (b) of this section shall establish a written Exposure Control Plan designed to eliminate or minimize employee exposure.

(ii) The Exposure Control Plan shall contain at least the following elements:

(A) The exposure determination required by paragraph (c)(2),

(B) The schedule and method of implementation for paragraphs (d) Methods of Compliance, (e) HIV and HBV Research Laboratories and Production Facilities, (f) Hepatitis B Vaccination and Post-Exposure Evaluation and Follow-up, (g) Communication of Hazards to Employees, and (h) Recordkeeping, of this standard, and

(C) The procedure for the evaluation of circumstances surrounding exposure incidents as required by paragraph (f)(3)(i) of this standard.

(iii) Each employer shall ensure that a copy of the Exposure Control Plan is accessible to employees in accordance with 29 CFR 1910.1020(e).

(iv) The Exposure Control Plan shall be reviewed and updated at least annually and whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure and to reflect new or revised employee positions with occupational exposure. The review and update of such plans shall also:

(A) Reflect changes in technology that eliminate or reduce exposure to bloodborne pathogens; and

(B) Document annually consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure.

(v) An employer, who is required to establish an Exposure Control Plan shall solicit input from non-managerial employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls and shall document the solicitation in the Exposure Control Plan.

(vi) The Exposure Control Plan shall be made available to the Assistant Secretary and the Director upon request for examination and copying.

(2) Exposure determination.

(i) Each employer who has an employee(s) with occupational exposure as defined by paragraph (b) of this section shall prepare an exposure determination. This exposure determination shall contain the following:

(A) A list of all job classifications in which all employees in those job classifications have occupational exposure;

(B) A list of job classifications in which some employees have occupational exposure, and

(C) A list of all tasks and procedures or groups of closely related task and procedures in which occupational exposure occurs and that are performed by employees in job classifications listed in accordance with the provisions of paragraph (c)(2)(i)(B) of this standard.

(ii) This exposure determination shall be made without regard to the use of personal protective equipment.

(d) Methods of compliance--

(1) General. Universal precautions shall be observed to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

(2) Engineering and work practice controls.
(i) Engineering and work practice controls shall be used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be used.

(ii) Engineering controls shall be examined and maintained or replaced on a regular schedule to ensure their effectiveness.

(iii) Employers shall provide handwashing facilities which are readily accessible to employees.

(iv) When provision of handwashing facilities is not feasible, the employer shall provide either an appropriate antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. When antiseptic hand cleansers or towelettes are used, hands shall be washed with soap and running water as soon as feasible.

(v) Employers shall ensure that employees wash their hands immediately or as soon as feasible after removal of gloves or other personal protective equipment.

(vi) Employers shall ensure that employees wash hands and any other skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or other potentially infectious materials.

(vii) Contaminated needles and other contaminated sharps shall not be bent, recapped, or removed except as noted in paragraphs (d)(2)(vii)(A) and (d)(2)(vii)(B) below. Shearing or breaking of contaminated needles is prohibited.

(A) Contaminated needles and other contaminated sharps shall not be bent, recapped or removed unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical or dental procedure.

(B) Such bending, recapping or needle removal must be accomplished through the use of a mechanical device or a one-handed technique.

(viii) Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly reprocessed. These containers shall be:

(A) Puncture resistant;

(B) Labeled or color-coded in accordance with this standard;

(C) Leakproof on the sides and bottom; and

(D) In accordance with the requirements set forth in paragraph (d)(4)(ii)(E) for reusable sharps.

(ix) Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure.

(x) Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on countertops or benchtops where blood or other potentially infectious materials are present.

(xi) All procedures involving blood or other potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.

(xii) Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

(xiii) Specimens of blood or other potentially infectious materials shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport, or shipping.

(A) The container for storage, transport, or shipping shall be labeled or color-coded according to paragraph (g)(1)(i) and closed prior to being stored, transported, or shipped. When a facility utilizes Universal Precautions in the handling of all specimens, the labeling/color-coding of specimens is
(B) If outside contamination of the primary container occurs, the primary container shall be placed within a second container which prevents leakage during handling, processing, storage, transport, or shipping and is labeled or color-coded according to the requirements of this standard.

(C) If the specimen could puncture the primary container, the primary container shall be placed within a secondary container which is puncture-resistant in addition to the above characteristics.

(xiv) Equipment which may become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary, unless the employer can demonstrate that decontamination of such equipment or portions of such equipment is not feasible.

(A) A readily observable label in accordance with paragraph (g)(1)(i)(H) shall be attached to the equipment stating which portions remain contaminated.

(B) The employer shall ensure that this information is conveyed to all affected employees, the servicing representative, and/or the manufacturer, as appropriate, prior to handling, servicing, or shipping so that appropriate precautions will be taken.

(3) Personal protective equipment--

(i) Provision. When there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate personal protective equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protection, and mouthpieces, resuscitation bags, pocket masks, or other ventilation devices. Personal protective equipment will be considered “appropriate” only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

(ii) Use. The employer shall ensure that the employee uses appropriate personal protective equipment unless the employer shows that the employee temporarily and briefly declined to use personal protective equipment when, under rare and extraordinary circumstances, it was the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgement, the circumstances shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future.

(iii) Accessibility. The employer shall ensure that appropriate personal protective equipment in the appropriate sizes is readily accessible at the worksite or is issued to employees. Hypoallergenic gloves, glove liners, powderless gloves, or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.

(iv) Cleaning, Laundering, and Disposal. The employer shall clean, launder, and dispose of personal protective equipment required by paragraphs (d) and (e) of this standard, at no cost to the employee.

(v) Repair and Replacement. The employer shall repair or replace personal protective equipment as needed to maintain its effectiveness, at no cost to the employee.

(vi) If a garment(s) is penetrated by blood or other potentially infectious materials, the garment(s) shall be removed immediately or as soon as feasible.
(vii) All personal protective equipment shall be removed prior to leaving the work area.

(viii) When personal protective equipment is removed it shall be placed in an appropriately designated area or container for storage, washing, decontamination or disposal.

(ix) Gloves. Gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood, other potentially infectious materials, mucous membranes, and non-intact skin; when performing vascular access procedures except as specified in paragraph (d)(3)(ix)(D); and when handling or touching contaminated items or surfaces.

(A) Disposable (single use) gloves such as surgical or examination gloves, shall be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised.

(B) Disposable (single use) gloves shall not be washed or decontaminated for re-use.

(C) Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised. However, they must be discarded if they are cracked, peeling, torn, punctured, or exhibit other signs of deterioration or when their ability to function as a barrier is compromised.

(D) If an employer in a volunteer blood donation center judges that routine gloving for all phlebotomies is not necessary then the employer shall:

1. Periodically reevaluate this policy;
2. Make gloves available to all employees who wish to use them for phlebotomy;
3. Not discourage the use of gloves for phlebotomy; and
4. Require that gloves be used for phlebotomy in the following circumstances:
   (i) When the employee has cuts, scratches, or other breaks in his or her skin;
   (ii) When the employee judges that hand contamination with blood may occur, for example, when performing phlebotomy on an uncooperative source individual; and
   (iii) When the employee is receiving training in phlebotomy.

(x) Masks, Eye Protection, and Face Shields. Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin-length face shields, shall be worn whenever splashes, spray, spatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated.

(xi) Gowns, Aprons, and Other Protective Body Clothing. Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, clinic jackets, or similar outer garments shall be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated.

(xii) Surgical caps or hoods and/or shoe covers or boots shall be worn in instances when gross contamination can reasonably be anticipated (e.g., autopsies, orthopaedic surgery).

(4) Housekeeping--

(i) General. Employers shall ensure that the worksite is maintained in a clean and sanitary condition. The employer shall determine and implement an appropriate written schedule for cleaning and method of decontamination based upon the location within the facility, type of surface to be cleaned, type of soil present, and tasks or procedures being performed in the area.

(ii) All equipment and environmental and working surfaces shall be cleaned and decontaminated after contact with blood or other
potentially infectious materials.

(A) Contaminated work surfaces shall be decontaminated with an appropriate disinfectant after completion of procedures; immediately or as soon as feasible when surfaces are overtly contaminated or after any spill of blood or other potentially infectious materials; and at the end of the work shift if the surface may have become contaminated since the last cleaning.

(B) Protective coverings, such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment and environmental surfaces, shall be removed and replaced as soon as feasible when they become overtly contaminated or at the end of the workshift if they may have become contaminated during the shift.

(C) All bins, pails, cans, and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials shall be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

(D) Broken glassware which may be contaminated shall not be picked up directly with the hands. It shall be cleaned up using mechanical means, such as a brush and dust pan, tongs, or forceps.

(E) Reusable sharps that are contaminated with blood or other potentially infectious materials shall not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

(iii) Regulated Waste--

(A) Contaminated Sharps Discarding and Containment.

(1) Contaminated sharps shall be discarded immediately or as soon as feasible in containers that are:

(i) Closable;

(ii) Puncture resistant;

(iii) Leakproof on sides and bottom; and

(iv) Labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard.

(2) During use, containers for contaminated sharps shall be:

(i) Easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found (e.g., laundries);

(ii) Maintained upright throughout use; and

(iii) Replaced routinely and not be allowed to overfill.

(3) When moving containers of contaminated sharps from the area of use, the containers shall be:

(i) Closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping;

(ii) Placed in a secondary container if leakage is possible. The second container shall be:

(A) Closable;

(B) Constructed to contain all contents and prevent leakage during handling, storage, transport, or shipping; and

(C) Labeled or color-coded according to paragraph (g)(1)(i) of this standard.

(4) Reusable containers shall not be opened, emptied, or cleaned manually
or in any other manner which would expose employees to the risk of percutaneous injury.

(B) Other Regulated Waste Containment--

(1) Regulated waste shall be placed in containers which are:

(i) Closable;

(ii) Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping;

(iii) Labeled or color-coded in accordance with paragraph (g)(1)(i) this standard; and

(iv) Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

(2) If outside contamination of the regulated waste container occurs, it shall be placed in a second container. The second container shall be:

(i) Closable;

(ii) Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping;

(iii) Labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard; and

(iv) Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

(C) Disposal of all regulated waste shall be in accordance with applicable regulations of the United States, States and Territories, and political subdivisions of States and Territories.

(iv) Laundry.

(A) Contaminated laundry shall be handled as little as possible with a minimum of agitation.

(1) Contaminated laundry shall be bagged or containerized at the location where it was used and shall not be sorted or rinsed in the location of use.

(2) Contaminated laundry shall be placed and transported in bags or containers labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard. When a facility utilizes Universal Precautions in the handling of all soiled laundry, alternative labeling or color-coding is sufficient if it permits all employees to recognize the containers as requiring compliance with Universal Precautions.

(3) Whenever contaminated laundry is wet and presents a reasonable likelihood of soak-through of or leakage from the bag or container, the laundry shall be placed and transported in bags or containers which prevent soak-through and/or leakage of fluids to the exterior.

(B) The employer shall ensure that employees who have contact with contaminated laundry wear protective gloves and other appropriate personal protective equipment.

(C) When a facility ships contaminated laundry off-site to a second facility which does not utilize Universal Precautions in the handling of all laundry, the facility generating the contaminated laundry must place such laundry in bags or containers which are labeled or color-coded in accordance with paragraph (g)(1)(i).

(e) HIV and HBV Research Laboratories and Production Facilities.

(1) This paragraph applies to research laboratories and production facilities engaged in the culture, production, concentration, experimentation, and manipulation of HIV and HBV. It does not apply to clinical or diagnostic
laboratories engaged solely in the analysis of blood, tissues, or organs. These requirements apply in addition to the other requirements of the standard.

(2) Research laboratories and production facilities shall meet the following criteria:

(i) Standard microbiological practices. All regulated waste shall either be incinerated or decontaminated by a method such as autoclaving known to effectively destroy bloodborne pathogens.

(ii) Special practices.

(A) Laboratory doors shall be kept closed when work involving HIV or HBV is in progress.

(B) Contaminated materials that are to be decontaminated at a site away from the work area shall be placed in a durable, leakproof, labeled or color-coded container that is closed before being removed from the work area.

(C) Access to the work area shall be limited to authorized persons. Written policies and procedures shall be established whereby only persons who have been advised of the potential biohazard, who meet any specific entry requirements, and who comply with all entry and exit procedures shall be allowed to enter the work areas and animal rooms.

(D) When other potentially infectious materials or infected animals are present in the work area or containment module, a hazard warning sign incorporating the universal biohazard symbol shall be posted on all access doors. The hazard warning sign shall comply with paragraph (g)(1)(ii) of this standard.

(E) All activities involving other potentially infectious materials shall be conducted in biological safety cabinets or other physical-containment devices within the containment module. No work with these other potentially infectious materials shall be conducted on the open bench.

(F) Laboratory coats, gowns, smocks, uniforms, or other appropriate protective clothing shall be used in the work area and animal rooms. Protective clothing shall not be worn outside of the work area and shall be decontaminated before being laundered.

(G) Special care shall be taken to avoid skin contact with other potentially infectious materials. Gloves shall be worn when handling infected animals and when making hand contact with other potentially infectious materials is unavoidable.

(H) Before disposal all waste from work areas and from animal rooms shall either be incinerated or decontaminated by a method such as autoclaving known to effectively destroy bloodborne pathogens.

(I) Vacuum lines shall be protected with liquid disinfectant traps and high-efficiency particulate air (HEPA) filters or filters of equivalent or superior efficiency and which are checked routinely and maintained or replaced as necessary.

(J) Hypodermic needles and syringes shall be used only for parenteral injection and aspiration of fluids from laboratory animals and diaphragm bottles. Only needle-locking syringes or disposable syringe-needle units (i.e., the needle is integral to the syringe) shall be used for the injection or aspiration of other potentially infectious materials. Extreme caution shall be used when handling needles and syringes. A needle shall not be bent, sheared, replaced in the sheath or guard, or removed from the syringe following use. The needle and syringe shall be promptly placed in a puncture-resistant container and autoclaved or decontaminated before reuse or disposal.

(K) All spills shall be immediately contained and cleaned up by appropriate professional staff or others properly trained and equipped to work with potentially concentrated infectious materials.

(L) A spill or accident that results in an
exposure incident shall be immediately reported to the laboratory director or other responsible person.

(M) A biosafety manual shall be prepared or adopted and periodically reviewed and updated at least annually or more often if necessary. Personnel shall be advised of potential hazards, shall be required to read instructions on practices and procedures, and shall be required to follow them.

(iii) Containment equipment.

(A) Certified biological safety cabinets (Class I, II, or III) or other appropriate combinations of personal protection or physical containment devices, such as special protective clothing, respirators, centrifuge safety cups, sealed centrifuge rotors, and containment caging for animals, shall be used for all activities with other potentially infectious materials that pose a threat of exposure to droplets, splashes, spills, or aerosols.

(B) Biological safety cabinets shall be certified when installed, whenever they are moved and at least annually.

(3) HIV and HBV research laboratories shall meet the following criteria:

(i) Each laboratory shall contain a facility for hand washing and an eye wash facility which is readily available within the work area.

(ii) An autoclave for decontamination of regulated waste shall be available.

(4) HIV and HBV production facilities shall meet the following criteria:

(i) The work areas shall be separated from areas that are open to unrestricted traffic flow within the building. Passage through two sets of doors shall be the basic requirement for entry into the work area from access corridors or other contiguous areas. Physical separation of the high-containment work area from access corridors or other areas or activities may also be provided by a double-doored clothes-change room (showers may be included), airlock, or other access facility that requires passing through two sets of doors before entering the work area.

(ii) The surfaces of doors, walls, floors and ceilings in the work area shall be water resistant so that they can be easily cleaned. Penetrations in these surfaces shall be sealed or capable of being sealed to facilitate decontamination.

(iii) Each work area shall contain a sink for washing hands and a readily available eye wash facility. The sink shall be foot, elbow, or automatically operated and shall be located near the exit door of the work area.

(iv) Access doors to the work area or containment module shall be self-closing.

(v) An autoclave for decontamination of regulated waste shall be available within or as near as possible to the work area.

(vi) A ducted exhaust-air ventilation system shall be provided. This system shall create directional airflow that draws air into the work area through the entry area. The exhaust air shall not be recirculated to any other area of the building, shall be discharged to the outside, and shall be dispersed away from occupied areas and air intakes. The proper direction of the airflow shall be verified (i.e., into the work area).

(5) Training Requirements. Additional training requirements for employees in HIV and HBV research laboratories and HIV and HBV production facilities are specified in paragraph (g)(2)(ix).

(f) Hepatitis B vaccination and post-exposure evaluation and follow-up--

(1) General.

(i) The employer shall make available the hepatitis B vaccine and vaccination series to all employees who have occupational exposure, and post-exposure evaluation and follow-up to all employees who have had an exposure incident.

(ii) The employer shall ensure that all medical evaluations and procedures including the
hepatitis B vaccine and vaccination series and post-exposure evaluation and follow-up, including prophylaxis, are:

(A) Made available at no cost to the employee;

(B) Made available to the employee at a reasonable time and place;

(C) Performed by or under the supervision of a licensed physician or by or under the supervision of another licensed healthcare professional; and

(D) Provided according to recommendations of the U.S. Public Health Service current at the time these evaluations and procedures take place, except as specified by this paragraph (f).

(iii) The employer shall ensure that all laboratory tests are conducted by an accredited laboratory at no cost to the employee.

(2) Hepatitis B Vaccination.

(i) Hepatitis B vaccination shall be made available after the employee has received the training required in paragraph (g)(2)(vii)(I) and within 10 working days of initial assignment to all employees who have occupational exposure unless the employee has previously received the complete hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.

(ii) The employer shall not make participation in a prescreening program a prerequisite for receiving hepatitis B vaccination.

(iii) If the employee initially declines hepatitis B vaccination but at a later date while still covered under the standard decides to accept the vaccination, the employer shall make available hepatitis B vaccination at that time.

(iv) The employer shall assure that employees who decline to accept hepatitis B vaccination offered by the employer sign the statement in appendix A.

(v) If a routine booster dose(s) of hepatitis B vaccine is recommended by the U.S. Public Health Service at a future date, such booster dose(s) shall be made available in accordance with section (f)(1)(ii).

(3) Post-exposure Evaluation and Follow-up. Following a report of an exposure incident, the employer shall make immediately available to the exposed employee a confidential medical evaluation and follow-up, including at least the following elements:

(i) Documentation of the route(s) of exposure, and the circumstances under which the exposure incident occurred;

(ii) Identification and documentation of the source individual, unless the employer can establish that identification is infeasible or prohibited by state or local law;

(A) The source individual's blood shall be tested as soon as feasible and after consent is obtained in order to determine HBV and HIV infectivity. If consent is not obtained, the employer shall establish that legally required consent cannot be obtained. When the source individual's consent is not required by law, the source individual's blood, if available, shall be tested and the results documented.

(B) When the source individual is already known to be infected with HBV or HIV, testing for the source individual's known HBV or HIV status need not be repeated.

(C) Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

(iii) Collection and testing of blood for HBV and HIV serological status;

(A) The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained.
(B) If the employee consents to baseline blood collection, but does not give consent at that time for HIV serologic testing, the sample shall be preserved for at least 90 days. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as feasible.

(iv) Post-exposure prophylaxis, when medically indicated, as recommended by the U.S. Public Health Service;

(v) Counseling; and

(vi) Evaluation of reported illnesses.

(4) Information Provided to the Healthcare Professional.

(i) The employer shall ensure that the healthcare professional responsible for the employee's Hepatitis B vaccination is provided a copy of this regulation.

(ii) The employer shall ensure that the healthcare professional evaluating an employee after an exposure incident is provided the following information:

(A) A copy of this regulation;

(B) A description of the exposed employee's duties as they relate to the exposure incident;

(C) Documentation of the route(s) of exposure and circumstances under which exposure occurred;

(D) Results of the source individual's blood testing, if available; and

(E) All medical records relevant to the appropriate treatment of the employee including vaccination status which are the employer's responsibility to maintain.


The employer shall obtain and provide the employee with a copy of the evaluating healthcare professional's written opinion within 15 days of the completion of the evaluation.

(i) The healthcare professional's written opinion for Hepatitis B vaccination shall be limited to whether Hepatitis B vaccination is indicated for an employee, and if the employee has received such vaccination.

(ii) The healthcare professional's written opinion for post-exposure evaluation and follow-up shall be limited to the following information:

(A) That the employee has been informed of the results of the evaluation; and

(B) That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment. (iii) All other findings or diagnoses shall remain confidential and shall not be included in the written report.

(6) Medical recordkeeping. Medical records required by this standard shall be maintained in accordance with paragraph (h)(1) of this section.

(g) Communication of hazards to employees--

(1) Labels and signs--

(i) Labels.

(A) Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious material; and other containers used to store, transport or ship blood or other potentially infectious materials, except as provided in paragraph (g)(1)(i)(E), (F) and (G).

(B) Labels required by this section shall include the following legend:
(C) These labels shall be fluorescent orange or orange-red or predominantly so, with lettering and symbols in a contrasting color.

(D) Labels shall be affixed as close as feasible to the container by string, wire, adhesive, or other method that prevents their loss or unintentional removal.

(E) Red bags or red containers may be substituted for labels.

(F) Containers of blood, blood components, or blood products that are labeled as to their contents and have been released for transfusion or other clinical use are exempted from the labeling requirements of paragraph (g).

(G) Individual containers of blood or other potentially infectious materials that are placed in a labeled container during storage, transport, shipment or disposal are exempted from the labeling requirement.

(H) Labels required for contaminated equipment shall be in accordance with this paragraph and shall also state which portions of the equipment remain contaminated.

(I) Regulated waste that has been decontaminated need not be labeled or color-coded.

(ii) Signs.

(A) The employer shall post signs at the entrance to work areas specified in paragraph (e), HIV and HBV Research Laboratory and Production Facilities, which shall bear the following legend:
(Name of the Infectious Agent)

(Special requirements for entering the area)

(Name, telephone number of the laboratory director or other responsible person.)

(B) These signs shall be fluorescent orange-red or predominantly so, with lettering and symbols in a contrasting color.

(2) Information and Training.

(i) The employer shall train each employee with occupational exposure in accordance with the requirements of this section. Such training must be provided at no cost to the employee and during working hours. The employer shall institute a training program and ensure employee participation in the program.

(ii) Training shall be provided as follows:

(A) At the time of initial assignment to tasks where occupational exposure may take place;

(B) At least annually thereafter.

(iii) [Reserved]

(iv) Annual training for all employees shall be provided within one year of their previous training.

(v) Employers shall provide additional training when changes such as modification of tasks or procedures or institution of new tasks or procedures affect the employee's occupational exposure. The additional training may be limited to addressing the new exposures created.

(vi) Material appropriate in content and vocabulary to educational level, literacy, and language of employees shall be used.

(vii) The training program shall contain at a minimum the following elements:

(A) An accessible copy of the regulatory text of this standard and an explanation of its contents;

(B) A general explanation of the epidemiology and symptoms of bloodborne diseases;

(C) An explanation of the modes of transmission of bloodborne pathogens;

(D) An explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the written plan;

(E) An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;

(F) An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment;

(G) Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment;

(H) An explanation of the basis for selection of personal protective equipment;

(I) Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;

(J) Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials;

(K) An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will
be made available;

(L) Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident;

(M) An explanation of the signs and labels and/or color coding required by paragraph (g)(1); and

(N) An opportunity for interactive questions and answers with the person conducting the training session.

(viii) The person conducting the training shall be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address.

(ix) Additional Initial Training for Employees in HIV and HBV Laboratories and Production Facilities. Employees in HIV or HBV research laboratories and HIV or HBV production facilities shall receive the following initial training in addition to the above training requirements.

(A) The employer shall assure that employees demonstrate proficiency in standard microbiological practices and techniques and in the practices and operations specific to the facility before being allowed to work with HIV or HBV.

(B) The employer shall assure that employees have prior experience in the handling of human pathogens or tissue cultures before working with HIV or HBV.

(C) The employer shall provide a training program to employees who have no prior experience in handling human pathogens. Initial work activities shall not include the handling of infectious agents. A progression of work activities shall be assigned as techniques are learned and proficiency is developed. The employer shall assure that employees participate in work activities involving infectious agents only after proficiency has been demonstrated.

(h) Recordkeeping--

(1) Medical Records.

(i) The employer shall establish and maintain an accurate record for each employee with occupational exposure, in accordance with 29 CFR 1910.1020.

(ii) This record shall include:

(A) The name and social security number of the employee;

(B) A copy of the employee's hepatitis B vaccination status including the dates of all the hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination as required by paragraph (f)(2);

(C) A copy of all results of examinations, medical testing, and follow-up procedures as required by paragraph (f)(3);

(D) The employer's copy of the healthcare professional's written opinion as required by paragraph (f)(5); and

(E) A copy of the information provided to the healthcare professional as required by paragraphs (f)(4)(ii)(B)(C) and (D).

(iii) Confidentiality. The employer shall ensure that employee medical records required by paragraph (h)(1) are:

(A) Kept confidential; and

(B) Not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as required by this section or as may be required by law.

(iv) The employer shall maintain the records required by paragraph (h) for at least the duration
of employment plus 30 years in accordance with 29 CFR 1910.1020.

(2) Training Records.

(i) Training records shall include the following information:

(A) The dates of the training sessions;

(B) The contents or a summary of the training sessions;

(C) The names and qualifications of persons conducting the training; and

(D) The names and job titles of all persons attending the training sessions.

(ii) Training records shall be maintained for 3 years from the date on which the training occurred.

(3) Availability.

(i) The employer shall ensure that all records required to be maintained by this section shall be made available upon request to the Assistant Secretary and the Director for examination and copying.

(ii) Employee training records required by this paragraph shall be provided upon request for examination and copying to employees, to employee representatives, to the Director, and to the Assistant Secretary.

(iii) Employee medical records required by this paragraph shall be provided upon request for examination and copying to the subject employee, to anyone having written consent of the subject employee, to the Director, and to the Assistant Secretary in accordance with 29 CFR 1910.1020.

(4) Transfer of Records.

(i) The employer shall comply with the requirements involving transfer of records set forth in 29 CFR 1910.1020(h).

(ii) If the employer ceases to do business and there is no successor employer to receive and retain the records for the prescribed period, the employer shall notify the Director, at least three months prior to their disposal and transmit them to the Director, if required by the Director to do so, within that three month period.

(5) [FN1] Sharps injury log.

1 So in original; added as (h)(5) by 66 FR 5325.

(i) The employer shall establish and maintain a sharps injury log for the recording of percutaneous injuries from contaminated sharps. The information in the sharps injury log shall be recorded and maintained in such manner as to protect the confidentiality of the injured employee. The sharps injury log shall contain, at a minimum:

(A) The type and brand of device involved in the incident,

(B) The department or work area where the exposure incident occurred, and
(C) An explanation of how the incident occurred.

(ii) The requirement to establish and maintain a sharps injury log shall apply to any employer who is required to maintain a log of occupational injuries and illnesses under 29 CFR 1904.

(iii) The sharps injury log shall be maintained for the period required by 29 CFR 1904.6.


AUTHORITY: Sections 4, 6, and 8 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 653, 655, and 657); Secretary of Labor's Order No. 12-71 (36 FR 8754), 8-76 (41 FR 25059), 9-83 (48 FR 35736), 1-90 (55 FR 9033), 6-96 (62 FR 111), 3-2000 (65 FR 50017), 5-2002 (67 FR 65008), or 5-2007 (72 FR 31160), as applicable.; All of subpart Z issued under section 6(b) of the Occupational Safety and Health Act, except those substances that have exposure limits listed in Tables Z-1, Z-2, and Z-3 of 29 CFR 1910.1000. The latter were issued under section 6(a) (29 U.S.C. 655(a));
Form of written consent.

(a) Required elements. A written consent to a disclosure under these regulations must include:

(1) The specific name or general designation of the program or person permitted to make the disclosure.

(2) The name or title of the individual or the name of the organization to which disclosure is to be made.

(3) The name of the patient.

(4) The purpose of the disclosure.

(5) How much and what kind of information is to be disclosed.

(6) The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient.

(7) The date on which the consent is signed.

(b) Sample consent form. The following form complies with paragraph (a) of this section, but other elements may be added.

1. I (name of patient) “[ ]” Request “[ ]” Authorize:

2. (name or general designation of program which is to make the disclosure)

3. To disclose: (kind and amount of information to be disclosed)

4. To: (name or title of the person or organization to which disclosure is to be made)

5. For (purpose of the disclosure)

6. Date (on which this consent is signed)

7. Signature of patient

8. Signature of parent or guardian (where required)

9. Signature of person authorized to sign in lieu of the patient (where required)

10. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: (specific date, event, or condition)

(c) Expired, deficient, or false consent. A disclosure may not be made on the basis of a consent which:

(1) Has expired;

(2) On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section;

(3) Is known to have been revoked; or

(4) Is known, or through a reasonable effort could be known, by the person holding the records to be materially false.
(Approved by the Office of Management and Budget under control number 0930–0099)

SOURCE: 52 FR 21803, June 9, 1987; 60 FR 22297, May 5, 1995, unless otherwise noted.


Current through February 12, 2010; 75 FR 6995
§ 424.32 Basic requirements for all claims.

(a) A claim must meet the following requirements:

(1) A claim must be filed with the appropriate intermediary or carrier on a form prescribed by CMS in accordance with CMS instructions.

(2) A claim for physician services, clinical psychologist services, or clinical social worker services must include appropriate diagnostic coding for those services using ICD-9-CM.

(3) A claim must be signed by the beneficiary or on behalf of the beneficiary (in accordance with § 424.36).

(4) A claim must be filed within the time limits specified in § 424.44.

(5) All Part B claims for services furnished to SNF residents (whether filed by the SNF or by another entity) must include the SNF’s Medicare provider number and appropriate HCPCS coding.

(b) The prescribed forms for claims are the following:

CMS-1450--Uniform Institutional Provider Bill. (This form is for institutional provider billing for Medicare inpatient, outpatient and home health services.)

CMS-1490S--Request for Medicare payment. (For use by a patient to request payment for medical expenses.)

CMS-1500--Health Insurance Claim Form. (For use by physicians and other suppliers to request payment for medical services.)

CMS-1660--Request for Information-Medicare Payment for Services to a Patient now Deceased. (For use in requesting amounts payable under title XVIII to a deceased beneficiary.)

(c) Where claims forms are available. Excluding forms CMS-1450 and CMS-1500, all claims forms prescribed for use in the Medicare program are distributed free-of-charge to the public, institutions, or organizations. The CMS-1450 and CMS-1500 may be obtained only by commercial purchase. All other claims forms can be obtained upon request from CMS or any Social Security branch or district office, or from Medicare intermediaries or carriers. The CMS-1490S is also available at local Social Security Offices.

(d) Submission of electronic claims.

(1) Definitions. For purposes of this paragraph, the following terms have the following meanings:

(i) Claim means a transaction defined at 45 CFR 162.1101(a).

(ii) Electronic claim means a claim that is submitted via electronic media. A claim submitted via direct data entry is considered to be an electronic claim.

(iii) Direct data entry is defined at 45 CFR 162.103.

(iv) Electronic media is defined at 45 CFR 160.103.

(v) Initial Medicare claim means a claim submitted to Medicare for payment under Part A or Part B of the Medicare Program under title XVIII of the Act for initial processing, including claims sent to Medicare for the first time for secondary payment purposes. Initial Medicare claim excludes any adjustment or appeal of a previously submitted claim, and claims submitted for payment under Part C of the Medicare program under title XVIII of the Act.

(vi) Physician, practitioner, facility, or supplier is...
a Medicare provider or supplier other than a provider of services.

(vii) Provider of services means a provider of services as defined in section 1861(u) of the Act.

(viii) Small provider of services or small supplier means--

(A) A provider of services with fewer than 25 full-time equivalent employees; or

(B) A physician, practitioner, facility, or supplier with fewer than 10 full-time equivalent employees.

(2) Submission of electronic claims required. Except for claims to which paragraph (d)(3) or (d)(4) of this section applies, an initial Medicare claim may be paid only if submitted as an electronic claim for processing by the Medicare fiscal intermediary or carrier that serves the physician, practitioner, facility, supplier, or provider of services. This requirement does not apply to any other transactions, including adjustment or appeal of the initial Medicare claim.

(3) Exceptions to requirement to submit electronic claims. The requirement of paragraph (d)(2) of this section is waived for any initial Medicare claim when--

(i) There is no method available for the submission of an electronic claim. This exception includes claims submitted by Medicare beneficiaries and situations in which the standard adopted by the Secretary at 45 FR 162.1102 does not support all of the information necessary for payment of the claim. The Secretary may identify situations coming within this exception in guidance.

(ii) The entity submitting the claim is a small provider of services or small supplier.

(4) Unusual cases. The Secretary may waive the requirement of paragraph (d)(2) of this section in unusual cases as the Secretary finds appropriate. Unusual cases are deemed to exist in the following situations:

(i) The submission of dental claims.

(ii) There is a service interruption in the mode of submitting the electronic claim that is outside the control of the entity submitting the claim, for the period of the interruption.

(iii) The entity submitting the claim submits fewer than 10 claims to Medicare per month, on average.

(iv) The entity submitting the claim only furnishes services outside of the U.S. territory.

(v) On demonstration, satisfactory to the Secretary, of other extraordinary circumstances precluding submission of electronic claims.

(5) Effective date. This paragraph (d) is effective October 16, 2003, and applies to claims submitted on or after October 16, 2003.


AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

42 C. F. R. § 424.32, 42 CFR § 424.32

Current through February 12, 2010; 75 FR 6995

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§ 441.252 State plan requirements.

A State plan must provide that the Medicaid agency will make payment under the plan for sterilization procedures and hysterectomies only if all the requirements of this subpart were met.
§ 441.253 Sterilization of a mentally competent individual aged 21 or older.

FFP is available in expenditures for the sterilization of an individual only if--

(a) The individual is at least 21 years old at the time consent is obtained;

(b) The individual is not a mentally incompetent individual;

(c) The individual has voluntarily given informed consent in accordance with all the requirements prescribed in § 441.257 through 441.258; and

(d) At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.
§ 441.258 Consent form requirements.

(a) Content of consent form. The consent form must be a copy of the form appended to this subpart or another form approved by the Secretary.

(b) Required signatures. The consent form must be signed and dated by--

1. The individual to be sterilized;
2. The interpreter, if one was provided;
3. The person who obtained the consent; and
4. The physician who performed the sterilization procedure.

(c) Required certifications.

1. The person securing the consent must certify, by signing the consent form, that
   (i) Before the individual to be sterilized signed the consent form, he or she advised the individual to be sterilized that no Federal benefits may be withdrawn because of the decision not to be sterilized; (ii) he or she explained orally the requirements for informed consent as set forth on the consent form; and (iii) to the best of his or her knowledge and belief, the individual appeared mentally competent and knowingly and voluntarily consented to be sterilized. Except in the case of premature delivery or emergency abdominal surgery, the physician must further certify that at least 30 days have passed between the date of the individual's signature on the consent form and the date upon which the sterilization was performed.

2. In the case of premature delivery or emergency abdominal surgery performed within 30 days of consent, the physician must certify that the sterilization was performed less than 30 days, but not less than 72 hours after informed consent was obtained because of premature delivery or emergency abdominal surgery and--
   (i) In the case of premature delivery, must state the expected date of delivery; or
   (ii) In the case of abdominal surgery, must describe the emergency.

3. If an interpreter is provided, the interpreter must certify that he or she translated the information and advice presented orally and read the consent form and explained its contents to the individual to be sterilized and that, to the best of the interpreter's knowledge and belief, the individual understood what the interpreter told him or her.
A hospital must protect and promote each patient's rights.

(a) Standard: Notice of rights.

(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.

(2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must delegate the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum:

(i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.

(ii) The grievance process must specify time frames for review of the grievance and the provision of a response.

(iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.

(b) Standard: Exercise of rights.

(1) The patient has the right to participate in the development and implementation of his or her plan of care.

(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with § 489.100 of this part (Definition), § 489.102 of this part (Requirements for providers), and § 489.104 of this part (Effective dates).

(4) The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.

(c) Standard: Privacy and safety.

(1) The patient has the right to personal privacy.

(2) The patient has the right to receive care in a safe setting.

(3) The patient has the right to be free from all forms of abuse or harassment.

(d) Standard: Confidentiality of patient records.

(1) The patient has the right to the confidentiality of his or her clinical records.

(2) The patient has the right to access information contained in his or her clinical
records within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.

(e) Standard: Restraint or seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

(1) Definitions.

(i) A restraint is--

(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or

(B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

(ii) Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

(2) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient a staff member or others from harm.

(3) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

(4) The use of restraint or seclusion must be--

(i) In accordance with a written modification to the patient's plan of care; and

(ii) Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.

(5) The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under § 482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.

(6) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).

(7) The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

(8) Unless superseded by State law that is more restrictive--

(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:

(A) 4 hours for adults 18 years of age or older;

(B) 2 hours for children and adolescents 9 to 17 years of age; or

(C) 1 hour for children under 9 years of age; and

(ii) After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive
behavior, a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under § 482.12(c) of this part and authorized to order restraint or seclusion by hospital policy in accordance with State law must see and assess the patient.

(iii) Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospital policy.

(9) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

(10) The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy.

(11) Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed independent practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.

(12) When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention--

(i) By a--

(A) Physician or other licensed independent practitioner; or

(B) Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section.

(ii) To evaluate--

(A) The patient's immediate situation;

(B) The patient's reaction to the intervention;

(C) The patient's medical and behavioral condition; and

(D) The need to continue or terminate the restraint or seclusion.

(13) States are free to have requirements by statute or regulation that are more restrictive than those contained in paragraph (e)(12)(i) of this section.

(14) If the face-to-face evaluation specified in paragraph (e)(12) of this section is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under § 482.12(c) as soon as possible after the completion of the 1-hour face-to-face evaluation.

(15) All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored--

(i) Face-to-face by an assigned, trained staff member; or

(ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

(16) When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:

(i) The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;

(ii) A description of the patient's behavior and the intervention used;

(iii) Alternatives or other less restrictive interventions attempted (as applicable);

(iv) The patient's condition or symptom(s) that
warranted the use of the restraint or seclusion; and

(v) The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

(f) Standard: Restraint or seclusion: Staff training requirements. The patient has the right to safe implementation of restraint or seclusion by trained staff.

(1) Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion--

(i) Before performing any of the actions specified in this paragraph;

(ii) As part of orientation; and

(iii) Subsequently on a periodic basis consistent with hospital policy.

(2) Training content. The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

(i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.

(ii) The use of nonphysical intervention skills.

(iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.

(iv) The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);

(v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.

(vi) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation.

(vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

(3) Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.

(4) Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.

(g) Standard: Death reporting requirements: Hospitals must report deaths associated with the use of seclusion or restraint.

(1) The hospital must report the following information to CMS:

(i) Each death that occurs while a patient is in restraint or seclusion.

(ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

(iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. “Reasonable to assume” in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

(2) Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.

(3) Staff must document in the patient's medical record the date and time the death was reported to CMS.
42 CFR § 482.13

[64 FR 36088, July 2, 1999; 71 FR 71426, Dec. 8, 2006]


AUTHORITY: Secs. 1102, 1871 and 1881 of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr), unless otherwise noted.

42 C. F. R. § 482.13, 42 CFR § 482.13

Current through February 12, 2010; 75 FR 6995

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42 CFR § 428.51

Effective: January 1, 2008

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

(a) Standard: Organization and staffing. The organization of the surgical services must be appropriate to the scope of the services offered.

(1) The operating rooms must be supervised by an experienced registered nurse or a doctor of medicine or osteopathy.

(2) Licensed practical nurses (LPNs) and surgical technologists (operating room technicians) may serve as “scrub nurses” under the supervision of a registered nurse.

(3) Qualified registered nurses may perform circulating duties in the operating room. In accordance with applicable State laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies.

(4) Surgical privileges must be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The surgical service must maintain a roster of practitioners specifying the surgical privileges of each practitioner.

(b) Standard: Delivery of service. Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.

(1) Prior to surgery or a procedure requiring anesthesia services and except in the case of emergencies:

(i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration.

(ii) An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration.

(2) A properly executed informed consent form for the operation must be in the patient's chart before surgery, except in emergencies.

(3) The following equipment must be available to the operating room suites: call-in-system, cardiac monitor, resuscitator, defibrillator, aspirator, and tracheotomy set.

(4) There must be adequate provisions for immediate post-operative care.

(5) The operating room register must be complete and up-to-date.

(6) An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon.

[72 FR 66933, Nov. 27, 2007]
42 C.F.R. § 482.51


AUTHORITY: Secs. 1102, 1871 and 1881 of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr), unless otherwise noted.

42 C. F. R. § 482.51, 42 CFR § 482.51

Current through February 12, 2010; 75 FR 6995

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42 CFR § 483.75

Effective: January 1, 2008

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

(a) Standard: Organization and staffing. The organization of the surgical services must be appropriate to the scope of the services offered:

(1) The operating rooms must be supervised by an experienced registered nurse or a doctor of medicine or osteopathy.

(2) Licensed practical nurses (LPNs) and surgical technologists (operating room technicians) may serve as “scrub nurses” under the supervision of a registered nurse.

(3) Qualified registered nurses may perform circulating duties in the operating room. In accordance with applicable State laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies.

(4) Surgical privileges must be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The surgical service must maintain a roster of practitioners specifying the surgical privileges of each practitioner.

(b) Standard: Delivery of service. Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.

(1) Prior to surgery or a procedure requiring anesthesia services and except in the case of emergencies:

(i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration.

(ii) An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration.

(2) A properly executed informed consent form for the operation must be in the patient's chart before surgery, except in emergencies.

(3) The following equipment must be available to the operating room suites: call-in-system, cardiac monitor, resuscitator, defibrillator, aspirator, and tracheotomy set.

(4) There must be adequate provisions for immediate post-operative care.

(5) The operating room register must be complete and up-to-date.

(6) An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon.

[72 FR 66933, Nov. 27, 2007]


AUTHORITY: Secs. 1102, 1871 and 1881 of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr), unless otherwise noted.
§ 483.75 Administration.

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, psychosocial well-being of each resident.

(a) Licensure. A facility must be licensed under applicable State and local law.

(b) Compliance with Federal, State, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

(c) Relationship to other HHS regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of handicap (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); protection of human subjects of research (45 CFR part 46); and fraud and abuse (45 CFR part 455). Although these regulations are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.

(d) Governing body.

(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and

(2) The governing body appoints the administrator who is--

(i) Licensed by the State where licensing is required; and

(ii) Responsible for management of the facility.

(e) Required training of nursing aides--

(1) Definitions.

Licensed health professional means a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

Nurse aide means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in § 488.301 of this chapter.

(2) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless:

(i) That individual is competent to provide nursing and nursing related services; and

(ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§ 483.151-483.154 of this part; or

(B) That individual has been deemed or determined competent as provided in § 483.150 (a) and (b).

(3) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirement in paragraphs (e)(2)(i)
and (ii) of this section.

(4) Competency. A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual--

(i) Is a full-time employee in a State-approved training and competency evaluation program;

(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or

(iii) Has been deemed or determined competent as provided in § 483.150 (a) and (b).

(5) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless--

(i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or

(ii) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

(6) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.

(7) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

(8) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must--

(i) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year;

(ii) Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and

(iii) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

(f) Proficiency of Nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(g) Staff qualifications.

(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.

(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.

(h) Use of outside resources.

(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or (with respect to services furnished to NF residents and dental services furnished to SNF residents) an agreement described in paragraph (h)(2) of this section.

(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for--

(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and

(ii) The timeliness of the services.

(i) Medical director.
(1) The facility must designate a physician to serve as medical director.

(2) The medical director is responsible for--

(i) Implementation of resident care policies; and

(ii) The coordination of medical care in the facility.

(j) Level B requirement: Laboratory services.

(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.

(ii) If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in part 493 of this chapter.

(iii) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter.

(iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.

(2) The facility must--

(i) Provide or obtain laboratory services only when ordered by the attending physician;

(ii) Promptly notify the attending physician of the findings;

(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and

(iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.

(k) Radiology and other diagnostic services.

(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in § 482.26 of this subchapter.

(ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.

(2) The facility must--

(i) Provide or obtain radiology and other diagnostic services only when ordered by the attending physician;

(ii) Promptly notify the attending physician of the findings;

(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and

(iv) File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.

(l) Clinical records.

(1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are--

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized.

(2) Clinical records must be retained for--

(i) The period of time required by State law; or

(ii) Five years from the date of discharge when there is no requirement in State law; or

(iii) For a minor, three years after a resident reaches legal age under State law.
(3) The facility must safeguard clinical record information against loss, destruction, or unauthorized use;

(4) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by--

(i) Transfer to another health care institution;

(ii) Law;

(iii) Third party payment contract; or

(iv) The resident.

(5) The clinical record must contain--

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The plan of care and services provided;

(iv) The results of any preadmission screening conducted by the State; and

(v) Progress notes.

(m) Disaster and emergency preparedness.

(1) The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

(2) The facility must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.

(n) Transfer agreement.

(1) In accordance with section 1861(1) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that--

(i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician; and

(ii) Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.

(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.

(o) Quality assessment and assurance.

(1) A facility must maintain a quality assessment and assurance committee consisting of--

(i) The director of nursing services;

(ii) A physician designated by the facility; and

(iii) At least 3 other members of the facility's staff.

(2) The quality assessment and assurance committee--

(i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and

(ii) Develops and implements appropriate plans of action to correct identified quality deficiencies.

(3) A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

(4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

(p) Disclosure of ownership.

(1) The facility must comply with the disclosure requirements of § § 420.206 and 455.104 of this chapter.

(2) The facility must provide written notice to the State agency responsible for licensing the facility at
the time of change, if a change occurs in--

(i) Persons with an ownership or control interest, as defined in § 420.201 and 455.101 of this chapter;

(ii) The officers, directors, agents, or managing employees;

(iii) The corporation, association, or other company responsible for the management of the facility; or

(iv) The facility's administrator or director of nursing.

(3) The notice specified in paragraph (p)(2) of this section must include the identity of each new individual or company.

(q) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in § 483.160 of this part.

§ 489.100 Definition.

For purposes of this part, "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.
§ 489.102 Requirements for providers.

(a) Hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices, and religious nonmedical health care institutions must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care, or patient care in the case of a patient in a religious nonmedical health care institution, by or through the provider and are required to:

(1) Provide written information to such individuals concerning--

   (i) An individual's rights under State law (whether statutory or recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individual's option, advance directives. Providers are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. Providers are to update and disseminate amended information as soon as possible, but no later than 90 days from the effective date of the changes to State law; and

   (ii) The written policies of the provider or organization respecting the implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience. At a minimum, a provider's statement of limitation should:

       (A) Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;

       (B) Identify the state legal authority permitting such objection; and

       (C) Describe the range of medical conditions or procedures affected by the conscience objection.

(2) Document in a prominent part of the individual's current medical record, or patient care record in the case of an individual in a religious nonmedical health care institution, whether or not the individual has executed an advance directive;

(3) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(4) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives. The provider must inform individuals that complaints concerning the advance directive requirements may be filed with the State survey and certification agency;

(5) Provide for education of staff concerning its policies and procedures on advance directives; and

(6) Provide for community education regarding issues concerning advance directives that may include material required in paragraph (a)(1) of this section, either directly or in concert with other providers and organizations. Separate community education materials may be developed and used, at the discretion of providers. The same written materials do not have to be provided in all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State law concerning advance directives. A provider must be able to document its community education efforts.

(b) The information specified in paragraph (a) of this section is furnished:

(1) In the case of a hospital, at the time of the individual's admission as an inpatient.

(2) In the case of a skilled nursing facility at the time of the individual's admission as a resident.

(3) In the case of a home health agency, in
advance of the individual coming under the care of the agency. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.

(ii) In the case of personal care services, in advance of the individual coming under the care of the personal care services provider. The personal care provider may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.

(4) In the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program.

c) The providers listed in paragraph (a) of this section--

(1) Are not required to provide care that conflicts with an advance directive.

(2) Are not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive and State law allows any health care provider or any agent of such provider to conscientiously object.

d) Prepaid or eligible organizations (as specified in sections 1833(a)(1)(A) and 1876(b) of the Act) must meet the requirements specified in § 417.436 of this chapter.

e) If an adult individual is incapacitated at the time of admission or at the start of care and is unable to receive information (due to the incapacitating conditions or a mental disorder) or articulate whether or not he or she has executed an advance directive, then the provider may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The provider is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

§ 1003.132 Limitations.

No action under this part will be entertained unless commenced, in accordance with § 1003.109(a) of this part, within 6 years from the date on which the claim was presented, the request for payment was made, or the incident occurred.

[52 FR 49413, Dec. 31, 1987; 57 FR 3349, Jan. 29, 1992]
§ 160.103 Definitions.

<Compliance date of amendments to definitions, see 68 FR 8334.>

Except as otherwise provided, the following definitions apply to this subchapter:

Act means the Social Security Act.

ANSI stands for the American National Standards Institute.

Business associate: (1) Except as provided in paragraph (2) of this definition, business associate means, with respect to a covered entity, a person who:

(i) On behalf of such covered entity or of an organized health care arrangement (as defined in § 164.501 of this subchapter) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of:

(A) A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or

(B) Any other function or activity regulated by this subchapter; or

(ii) Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in § 164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

(2) A covered entity participating in an organized health care arrangement that performs a function or activity as described by paragraph (1)(i) of this definition for or on behalf of such organized health care arrangement, or that provides a service as described in paragraph (1)(ii) of this definition to or for such organized health care arrangement, does not, simply through the performance of such function or activity or the provision of such service, become a business associate of other covered entities participating in such organized health care arrangement.

(3) A covered entity may be a business associate of another covered entity.

Compliance date means the date by which a covered entity must comply with a standard, implementation specification, requirement, or modification adopted under this subchapter.

Covered entity means:

(1) A health plan.

(2) A health care clearinghouse.

(3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter.

Disclosure means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

EIN stands for the employer identification number assigned by the Internal Revenue Service, U.S. Department of the Treasury. The EIN is the taxpayer identifying number of an individual or other entity (whether or not an employer) assigned under one of the following:

(1) 26 U.S.C. 6011(b), which is the portion of the
Internal Revenue Code dealing with identifying the taxpayer in tax returns and statements, or corresponding provisions of prior law.

(2) 26 U.S.C. 6109, which is the portion of the Internal Revenue Code dealing with identifying numbers in tax returns, statements, and other required documents.

Electronic media means:

(1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

Electronic protected health information means information that comes within paragraphs (1)(i) or (1)(ii) of the definition of protected health information as specified in this section.

Employer is defined as it is in 26 U.S.C. 3401(d).

Group health plan (also see definition of health plan in this section) means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the Public Health Service Act (PHS Act), 42 U.S.C. 300gg-91(a)(2)), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that:

(1) Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or

(2) Is administered by an entity other than the employer that established and maintains the plan.

CMS stands for Centers for Medicare & Medicaid Services within the Department of Health and Human Services.

HHS stands for the Department of Health and Human Services.

Health care means care, services, or supplies related to the health of an individual. Health care includes, but is not limited to, the following:

(1) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and

(2) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

Health care clearinghouse means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that does either of the following functions:

(1) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

(2) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

Health care provider means a provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

Health information means any information, whether oral or recorded in any form or medium, that:

(1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care
clearinghouse; and

(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Health insurance issuer (as defined in section 2791(b)(2) of the PHS Act, 42 U.S.C. 300gg-91(b)(2) and used in the definition of health plan in this section) means an insurance company, insurance service, or insurance organization (including an HMO) that is engaged to engage in the business of insurance in a State and is subject to State law that regulates insurance. Such term does not include a group health plan.

Health maintenance organization (HMO) (as defined in section 2791(b)(3) of the PHS Act, 42 U.S.C. 300gg-91(b)(3) and used in the definition of health plan in this section) means a federally qualified HMO, an organization recognized as an HMO under State law, or a similar organization regulated for solvency under State law in the same manner and to the same extent as such an HMO.

Health plan means an individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).

(1) Health plan includes the following, singly or in combination:

(i) A group health plan, as defined in this section.

(ii) A health insurance issuer, as defined in this section.

(iii) An HMO, as defined in this section.

(iv) Part A or Part B of the Medicare program under title XVIII of the Act.

(v) The Medicaid program under title XIX of the Act, 42 U.S.C. 1396, et seq.

(vi) An issuer of a Medicare supplemental policy (as defined in section 1882(g)(1) of the Act, 42 U.S.C. 1395ss(g)(1)).

(vii) An issuer of a long-term care policy, excluding a nursing home fixed-indemnity policy.

(viii) An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.

(ix) The health care program for active military personnel under title 10 of the United States Code.

(x) The veterans health care program under 38 U.S.C. chapter 17.

(xi) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (as defined in 10 U.S.C. 1072(4)).

(xii) The Indian Health Service program under the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq.


(xiv) An approved State child health plan under title XXI of the Act, providing benefits for child health assistance that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397, et seq.


(xvi) A high risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.

(xvii) Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).

(2) Health plan excludes:

(i) Any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the PHS Act, 42 U.S.C. 300gg-91(c)(1); and

(ii) A government-funded program (other than one listed in paragraph (1)(i)-(xvi) of this definition):

(A) Whose principal purpose is other than providing, or paying the cost of, health care; or

(B) Whose principal activity is:
(1) The direct provision of health care to persons; or

(2) The making of grants to fund the direct provision of health care to persons.

Implementation specification means specific requirements or instructions for implementing a standard.

Individual means the person who is the subject of protected health information.

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and:

(1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

(i) That identifies the individual; or

(ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Modify or modification refers to a change adopted by the Secretary, through regulation, to a standard or an implementation specification.

Organized health care arrangement means:

(1) A clinically integrated care setting in which individuals typically receive health care from more than one health care provider;

(2) An organized system of health care in which more than one covered entity participates and in which the participating covered entities:

(i) Hold themselves out to the public as participating in a joint arrangement; and

(ii) Participate in joint activities that include at least one of the following:

(A) Utilization review, in which health care decisions by participating covered entities are reviewed by other participating covered entities or by a third party on their behalf;

(B) Quality assessment and improvement activities, in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf; or

(C) Payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating covered entities through the joint arrangement and if protected health information created or received by a covered entity is reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.

(3) A group health plan and a health insurance issuer or HMO with respect to such group health plan, but only with respect to protected health information created or received by such health insurance issuer or HMO that relates to individuals who are or who have been participants or beneficiaries in such group health plan;

(4) A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or

(5) The group health plans described in paragraph (4) of this definition and health insurance issuers or HMOs with respect to such group health plans, but only with respect to protected health information created or received by such health insurance issuers or HMOs that relates to individuals who are or have been participants or beneficiaries in any of such group health plans.

Protected health information means individually identifiable health information:

(1) Except as provided in paragraph (2) of this definition, that is:

(i) Transmitted by electronic media;

(ii) Maintained in electronic media; or

(iii) Transmitted or maintained in any other form or medium.

(2) Protected health information excludes individually identifiable health information in:

(i) Education records covered by the Family Educational Rights and Privacy Act, as amended.
(ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and

(iii) Employment records held by a covered entity in its role as employer.

Secretary means the Secretary of Health and Human Services or any other officer or employee of HHS to whom the authority involved has been delegated.

Small health plan means a health plan with annual receipts of $5 million or less.

Standard means a rule, condition, or requirement:

(1) Describing the following information for products, systems, services or practices:
   (i) Classification of components.
   (ii) Specification of materials, performance, or operations; or
   (iii) Delineation of procedures; or

(2) With respect to the privacy of individually identifiable health information.

Standard setting organization (SSO) means an organization accredited by the American National Standards Institute that develops and maintains standards for information transactions or data elements, or any other standard that is necessary for, or will facilitate the implementation of, this part.

State refers to one of the following:

(1) For a health plan established or regulated by Federal law, State has the meaning set forth in the applicable section of the United States Code for such health plan.

(2) For all other purposes, State means any of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.

Trading partner agreement means an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)

Transaction means the transmission of information between two parties to carry out financial or administrative activities related to health care. It includes the following types of information transmissions:

(1) Health care claims or equivalent encounter information.

(2) Health care payment and remittance advice.

(3) Coordination of benefits.

(4) Health care claim status.

(5) Enrollment and disenrollment in a health plan.

(6) Eligibility for a health plan.

(7) Health plan premium payments.

(8) Referral certification and authorization.

(9) First report of injury.

(10) Health claims attachments.

(11) Other transactions that the Secretary may prescribe by regulation.

Use means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

Workforce means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity.

§ 160.202 Definitions.

For purposes of this subpart, the following terms have the following meanings:

Contrary, when used to compare a provision of State law to a standard, requirement, or implementation specification adopted under this subchapter, means:

1. A covered entity would find it impossible to comply with both the State and federal requirements; or

2. The provision of State law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of part C of title XI of the Act or section 264 of Pub.L. 104-191, as applicable.

More stringent means, in the context of a comparison of a provision of State law and a standard, requirement, or implementation specification adopted under subpart E of part 164 of this subchapter, a State law that meets one or more of the following criteria:

1. With respect to a use or disclosure, the law prohibits or restricts a use or disclosure in circumstances under which such use or disclosure otherwise would be permitted under this subchapter, except if the disclosure is:
   i. Required by the Secretary in connection with determining whether a covered entity is in compliance with this subchapter; or
   ii. To the individual who is the subject of the individually identifiable health information.

2. With respect to the rights of an individual, who is the subject of the individually identifiable health information, regarding access to or amendment of individually identifiable health information, permits greater rights of access or amendment, as applicable.

3. With respect to information to be provided to an individual who is the subject of the individually identifiable health information about a use, a disclosure, rights, and remedies, provides the greater amount of information.

4. With respect to the form, substance, or the need for express legal permission from an individual, who is the subject of the individually identifiable health information, for use or disclosure of individually identifiable health information, provides requirements that narrow the scope or duration, increase the privacy protections afforded (such as by expanding the criteria for), or reduce the coercive effect of the circumstances surrounding the express legal permission, as applicable.

5. With respect to recordkeeping or requirements relating to accounting of disclosures, provides for the retention or reporting of more detailed information or for a longer duration.

6. With respect to any other matter, provides greater privacy protection for the individual who is the subject of the individually identifiable health information.

Relates to the privacy of individually identifiable health information means, with respect to a State law, that the State law has the specific purpose of protecting the privacy of health information or affects the privacy of health information in a direct, clear, and substantial way.

State law means a constitution, statute, regulation, rule, common law, or other State action having the force and effect of law.

[67 FR 53266, Aug. 14, 2002]
§ 160.203 General rule and exceptions.

A standard, requirement, or implementation specification adopted under this subchapter that is contrary to a provision of State law preempts the provision of State law. This general rule applies, except if one or more of the following conditions is met:

(a) A determination is made by the Secretary under § 160.204 that the provision of State law:

(1) Is necessary:

(i) To prevent fraud and abuse related to the provision of or payment for health care;

(ii) To ensure appropriate State regulation of insurance and health plans to the extent expressly authorized by statute or regulation;

(iii) For State reporting on health care delivery or costs; or

(iv) For purposes of serving a compelling need related to public health, safety, or welfare, and, if a standard, requirement, or implementation specification under part 164 of this subchapter is at issue, if the Secretary determines that the intrusion into privacy is warranted when balanced against the need to be served; or

(2) Has as its principal purpose the regulation of the manufacture, registration, distribution, dispensing, or other control of any controlled substances (as defined in 21 U.S.C. 802), or that is deemed a controlled substance by State law.

(b) The provision of State law relates to the privacy of individually identifiable health information and is more stringent than a standard, requirement, or implementation specification adopted under subpart E of part 164 of this subchapter.

(c) The provision of State law, including State procedures established under such law, as applicable, provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health surveillance, investigation, or intervention.

(d) The provision of State law requires a health plan to report, or to provide access to, information for the purpose of management audits, financial audits, program monitoring and evaluation, or the licensure or certification of facilities or individuals.

[67 FR 53266, Aug. 14, 2002]

<General Materials (GM) - References, Annotations, or Tables>
§ 164.103 Definitions.

As used in this part, the following terms have the following meanings:

Common control exists if an entity has the power, directly or indirectly, significantly to influence or direct the actions or policies of another entity.

Common ownership exists if an entity or entities possess an ownership or equity interest of 5 percent or more in another entity.

Covered functions means those functions of a covered entity the performance of which makes the entity a health plan, health care provider, or health care clearinghouse.

Health care component means a component or combination of components of a hybrid entity designated by the hybrid entity in accordance with § 164.105(a)(2)(iii)(C).

Hybrid entity means a single legal entity:

(1) That is a covered entity;

(2) Whose business activities include both covered and non-covered functions; and

(3) That designates health care components in accordance with paragraph § 164.105(a)(2)(iii)(C).

Plan sponsor is defined as defined at section 3(16)(B) of ERISA, 29 U.S.C. 1002(16)(B).

Required by law means a mandate contained in law that compels an entity to make a use or disclosure of protected health information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

[68 FR 8374, Feb. 20, 2003]
45 CFR § 164.501

Effective: September 23, 2009

Code of Federal Regulations Currentness
Title 45. Public Welfare
Subtitle A. Department of Health and Human Services (Refs & Annos)
Subchapter C. Administrative Data Standards and Related Requirements (Refs & Annos)
Part 164. Security and Privacy (Refs & Annos)
Subpart E. Privacy of Individually Identifiable Health Information

§ 164.501 Definitions.

As used in this subpart, the following terms have the following meanings:

Correctional institution means any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. Other persons held in lawful custody includes juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial.

Data aggregation means, with respect to protected health information created or received by a business associate in its capacity as the business associate of a covered entity, the combining of such protected health information by the business associate with the protected health information received by the business associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

Designated record set means:

(1) A group of records maintained by or for a covered entity that is:

(i) The medical records and billing records about individuals maintained by or for a covered health care provider;

(ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

(iii) Used, in whole or in part, by or for the covered entity to make decisions about individuals.

(2) For purposes of this paragraph, the term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

Direct treatment relationship means a treatment relationship between an individual and a health care provider that is not an indirect treatment relationship.

Health care operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions:

(1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

(2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

(3) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of § 164.514(g) are met, if applicable;
(4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(5) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

(6) Business management and general administrative activities of the entity, including, but not limited to:

(i) Management activities relating to implementation of and compliance with the requirements of this subchapter;

(ii) Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer.

(iii) Resolution of internal grievances;

(iv) The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and

(v) Consistent with the applicable requirements of §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

Health oversight agency means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.

Indirect treatment relationship means a relationship between an individual and a health care provider in which:

(1) The health care provider delivers health care to the individual based on the orders of another health care provider; and

(2) The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.

Inmate means a person incarcerated in or otherwise confined to a correctional institution.

Marketing means:

(1) To make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service, unless the communication is made:

(i) To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entity making the communication, including communications about: the entities participating in a health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits.

(ii) For treatment of the individual; or

(iii) For case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual.

Payment means:

(1) The activities undertaken by:

(i) A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or
(ii) A health care provider or health plan to obtain or provide reimbursement for the provision of health care; and

(2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:

(i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

(ii) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(iii) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;

(iv) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

(v) Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and

(vi) Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:

(A) Name and address;

(B) Date of birth;

(C) Social security number;

(D) Payment history;

(E) Account number; and

(F) Name and address of the health care provider and/or health plan.

Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Public health authority means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

Research means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.


45 C. F. R. § 164.501, 45 CFR § 164.501

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END OF DOCUMENT
§ 164.502 Uses and disclosures of protected health information: general rules.

(a) Standard. A covered entity may not use or disclose protected health information, except as permitted or required by this subpart or by subpart C of part 160 of this subchapter.

(1) Permitted uses and disclosures. A covered entity is permitted to use or disclose protected health information as follows:

(i) To the individual;

(ii) For treatment, payment, or health care operations, as permitted by and in compliance with § 164.506;

(iii) Incident to a use or disclosure otherwise permitted or required by this subpart, provided that the covered entity has complied with the applicable requirements of § 164.502(b), § 164.514(d), and § 164.530(c) with respect to such otherwise permitted or required use or disclosure;

(iv) Pursuant to and in compliance with a valid authorization under § 164.508;

(v) Pursuant to an agreement under, or as otherwise permitted by, § 164.510; and

(vi) As permitted by and in compliance with this section, § 164.512, or § 164.514(e), (f), or (g).

(2) Required disclosures. A covered entity is required to disclose protected health information:

(i) To an individual, when requested under, and required by § 164.524 or § 164.528; and

(ii) When required by the Secretary under subpart C of part 160 of this subchapter to investigate or determine the covered entity's compliance with this subpart.

(b) Standard: Minimum necessary.

(1) Minimum necessary applies. When using or disclosing protected health information or when requesting protected health information from another covered entity, a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

(2) Minimum necessary does not apply. This requirement does not apply to:

(i) Disclosures to or requests by a health care provider for treatment;

(ii) Uses or disclosures made to the individual, as permitted under paragraph (a)(1)(i) of this section or as required by paragraph (a)(2)(i) of this section;

(iii) Uses or disclosures made pursuant to an authorization under § 164.508;

(iv) Disclosures made to the Secretary in accordance with subpart C of part 160 of this subchapter;

(v) Uses or disclosures that are required by law, as described by § 164.512(a); and

(vi) Uses or disclosures that are required for compliance with applicable requirements of this subchapter.
(c) Standard: Uses and disclosures of protected health information subject to an agreed upon restriction. A covered entity that has agreed to a restriction pursuant to §164.522(a)(1) may not use or disclose the protected health information covered by the restriction in violation of such restriction, except as otherwise provided in §164.522(a).

(d) Standard: Uses and disclosures of de-identified protected health information.

(1) Uses and disclosures to create de-identified information. A covered entity may use protected health information to create information that is not individually identifiable health information or disclose protected health information only to a business associate for such purpose, whether or not the de-identified information is to be used by the covered entity.

(2) Uses and disclosures of de-identified information. Health information that meets the standard and implementation specifications for de-identification under §164.514(a) and (b) is considered not to be individually identifiable health information, i.e., de-identified. The requirements of this subpart do not apply to information that has been de-identified in accordance with the applicable requirements of §164.514, provided that:

(i) Disclosure of a code or other means of record identification designed to enable coded or otherwise de-identified information to be re-identified constitutes disclosure of protected health information; and

(ii) If de-identified information is re-identified, a covered entity may use or disclose such re-identified information only as permitted or required by this subpart.

(e)(1) Standard: Disclosures to business associates.

(i) A covered entity may disclose protected health information to a business associate and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurance that the business associate will appropriately safeguard the information.

(ii) This standard does not apply:

(A) With respect to disclosures by a covered entity to a health care provider concerning the treatment of the individual;

(B) With respect to disclosures by a group health plan or a health insurance issuer or HMO with respect to a group health plan to the plan sponsor, to the extent that the requirements of §164.504(f) apply and are met; or

(C) With respect to uses or disclosures by a health plan that is a government program providing public benefits, if eligibility for, or enrollment in, the health plan is determined by an agency other than the agency administering the health plan, or if the protected health information used to determine enrollment or eligibility in the health plan is collected by an agency other than the agency administering the health plan.

(iii) A covered entity that violates the satisfactory assurances it provided as a business associate of another covered entity will be in noncompliance with the standards, implementation specifications, and requirements of this paragraph and §164.504(e).

(2) Implementation specification: documentation. A covered entity must document the satisfactory assurances required by paragraph (e)(1) of this section through a written contract or other written agreement or arrangement with the business associate that meets the applicable requirements of §164.504(e).

(f) Standard: Deceased individuals. A covered entity must comply with the requirements of this subpart with respect to the protected health information of a deceased individual.

(g)(1) Standard: Personal representatives. As specified in this paragraph, a covered entity must, except as provided in paragraphs (g)(3) and (g)(5) of this section, treat a personal representative as the individual for purposes of this subchapter.

(2) Implementation specification: adults and emancipated minors. If under applicable law a
person has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, a covered entity must treat such person as a personal representative under this subchapter, with respect to protected health information relevant to such personal representation.

(3)(i) Implementation specification: unemancipated minors. If under applicable law a parent, guardian, or other person acting in loco parentis has authority to act on behalf of an individual who is an unemancipated minor in making decisions related to health care, a covered entity must treat such person as a personal representative under this subchapter, with respect to protected health information relevant to such personal representation, except that such person may not be a personal representative of an unemancipated minor, and the minor has the authority to act as an individual, with respect to protected health information pertaining to a health care service, if:

(A) The minor consents to such health care service; no other consent to such health care service is required by law, regardless of whether the consent of another person has also been obtained; and the minor has not requested that such person be treated as the personal representative;

(B) The minor may lawfully obtain such health care service without the consent of a parent, guardian, or other person acting in loco parentis, and the minor, a court, or another person authorized by law consents to such health care service; or

(C) A parent, guardian, or other person acting in loco parentis assents to an agreement of confidentiality between a covered health care provider and the minor with respect to such health care service.

(ii) Notwithstanding the provisions of paragraph (g)(3)(i) of this section:

(A) If, and to the extent, permitted or required by an applicable provision of State or other law, including applicable case law, a covered entity may disclose, or provide access in accordance with § 164.524, to, protected health information about an unemancipated minor to a parent, guardian, or other person acting in loco parentis;

(B) If, and to the extent, prohibited by an applicable provision of State or other law, including applicable case law, a covered entity may not disclose, or provide access in accordance with § 164.524, to, protected health information about an unemancipated minor to a parent, guardian, or other person acting in loco parentis; and

(C) Where the parent, guardian, or other person acting in loco parentis, is not the personal representative under paragraphs (g)(3)(i)(A), (B), or (C) of this section and where there is no applicable access provision under State or other law, including case law, a covered entity may provide or deny access under § 164.524 to a parent, guardian, or other person acting in loco parentis, if such action is consistent with State or other applicable law, provided that such decision must be made by a licensed health care professional, in the exercise of professional judgment.

(4) Implementation specification: Deceased individuals. If under applicable law an executor, administrator, or other person has authority to act on behalf of a deceased individual or of the individual's estate, a covered entity must treat such person as a personal representative under this subchapter, with respect to protected health information relevant to such personal representation.

(5) Implementation specification: Abuse, neglect, endangerment situations. Notwithstanding a State law or any requirement of this paragraph to the contrary, a covered entity may elect not to treat a person as the personal representative of an individual if:

(i) The covered entity has a reasonable belief that:

(A) The individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or

(B) Treating such person as the personal representative could endanger the individual; and
(ii) The covered entity, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the individual's personal representative.

(h) Standard: Confidential communications. A covered health care provider or health plan must comply with the applicable requirements of §164.522(b) in communicating protected health information.

(i) Standard: Uses and disclosures consistent with notice. A covered entity that is required by §164.520 to have a notice may not use or disclose protected health information in a manner inconsistent with such notice. A covered entity that is required by §164.520(b)(1)(iii) to include a specific statement in its notice if it intends to engage in an activity listed in §164.520(b)(1)(iii)(A)-(C), may not use or disclose protected health information for such activities, unless the required statement is included in the notice.

(j) Standard: Disclosures by whistleblowers and workforce member crime victims.

(1) Disclosures by whistleblowers. A covered entity is not considered to have violated the requirements of this subpart if a member of its workforce or a business associate discloses protected health information, provided that:

(i) The workforce member or business associate believes in good faith that the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public; and

(ii) The disclosure is to:

(A) A health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of the covered entity or to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the covered entity; or

(B) An attorney retained by or on behalf of the workforce member or business associate for the purpose of determining the legal options of the workforce member or business associate with regard to the conduct described in paragraph (j)(1)(i) of this section.

(2) Disclosures by workforce members who are victims of a crime. A covered entity is not considered to have violated the requirements of this subpart if a member of its workforce who is the victim of a criminal act discloses protected health information to a law enforcement official, provided that:

(i) The protected health information disclosed is about the suspected perpetrator of the criminal act; and

(ii) The protected health information disclosed is limited to the information listed in §164.512(f)(2)(i).

[67 FR 53267, Aug. 14, 2002]


45 C. F. R. § 164.502, 45 CFR § 164.502

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END OF DOCUMENT
§ 164.504 Uses and disclosures: Organizational requirements.

(a) Definitions. As used in this section:

Plan administration functions means administration functions performed by the plan sponsor of a group health plan on behalf of the group health plan and excludes functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor.

Summary health information means information, that may be individually identifiable health information, and:

(1) That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and

(2) From which the information described at § 164.514(b)(2)(i) has been deleted, except that the geographic information described in § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

(b) to (d) [Reserved]

(e)(1) Standard: Business associate contracts.

(i) The contract or other arrangement between the covered entity and the business associate required by § 164.502(e)(2) must meet the requirements of paragraph (e)(2) or (e)(3) of this section, as applicable.

(ii) A covered entity is not in compliance with the standards in § 164.502(e) and paragraph (e) of this section, if the covered entity knew of a pattern of activity or practice of the business associate that constituted a material breach or violation of the business associate's obligation under the contract or other arrangement, unless the covered entity took reasonable steps to cure the breach or end the violation, as applicable, and, if such steps were unsuccessful:

(A) Terminated the contract or arrangement, if feasible; or

(B) If termination is not feasible, reported the problem to the Secretary.

(ii) Provide that the business associate will:

(A) Not use or further disclose the information other than as permitted or required by the contract or as required by law;

(B) Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by its contract;

(C) Report to the covered entity any use or disclosure of the information not provided for by its contract of which it becomes aware;

(D) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from, or created or received by the business associate on behalf of, the covered entity agrees to the same restrictions and conditions that

apply to the business associate with respect to such information;

(E) Make available protected health information in accordance with § 164.524;

(F) Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with § 164.526;

(G) Make available the information required to provide an accounting of disclosures in accordance with § 164.528;

(H) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from, or created or received by the business associate on behalf of, the covered entity available to the Secretary for purposes of determining the covered entity's compliance with this subpart; and

(I) At termination of the contract, if feasible, return or destroy all protected health information received from, or created or received by the business associate on behalf of, the covered entity still maintains in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections of the contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(iii) Authorize termination of the contract by the covered entity, if the covered entity determines that the business associate has violated a material term of the contract.

(3) Implementation specifications: Other arrangements.

(i) If a covered entity and its business associate are both governmental entities:

(A) The covered entity may comply with paragraph (e) of this section by entering into a memorandum of understanding with the business associate that contains terms that accomplish the objectives of paragraph (e)(2) of this section.

(ii) If a business associate is required by law to perform a function or activity on behalf of a covered entity or to provide a service described in the definition of business associate in § 160.103 of this subchapter to a covered entity, such covered entity may disclose protected health information to the business associate to the extent necessary to comply with the legal mandate without meeting the requirements of this paragraph (e), provided that the covered entity attempts in good faith to obtain satisfactory assurances as required by paragraph (e)(3)(i) of this section, and, if such attempt fails, documents the attempt and the reasons that such assurances cannot be obtained.

(iii) The covered entity may omit from its other arrangements the termination authorization required by paragraph (e)(2)(iii) of this section, if such authorization is inconsistent with the statutory obligations of the covered entity or its business associate.

(4) Implementation specifications: Other requirements for contracts and other arrangements.

(i) The contract or other arrangement between the covered entity and the business associate may permit the business associate to use the information received by the business associate in its capacity as a business associate for the purposes described in paragraph (e)(4)(i) of this section, if:

(A) The disclosure is required by law; or

(B)(1) The business associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person; and
(2) The person notifies the business associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(f)(1) Standard: Requirements for group health plans.

(i) Except as provided under paragraph (f)(1)(ii) or (iii) of this section or as otherwise authorized under § 164.508, a group health plan, in order to disclose protected health information to the plan sponsor or to provide for or permit the disclosure of protected health information to the plan sponsor by a health insurance issuer or HMO with respect to the group health plan, must ensure that the plan documents restrict uses and disclosures of such information by the plan sponsor consistent with the requirements of this subpart.

(ii) The group health plan, or a health insurance issuer or HMO with respect to the group health plan, may disclose summary health information to the plan sponsor, if the plan sponsor requests the summary health information for the purpose of:

(A) Obtaining premium bids from health plans for providing health insurance coverage under the group health plan; or

(B) Modifying, amending, or terminating the group health plan.

(iii) The group health plan, or a health insurance issuer or HMO with respect to the group health plan, may disclose to the plan sponsor information on whether the individual is participating in the group health plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the plan.

(2) Implementation specifications: Requirements for plan documents. The plan documents of the group health plan must be amended to incorporate provisions to:

(i) Establish the permitted and required uses and disclosures of such information by the plan sponsor, provided that such permitted and required uses and disclosures may not be inconsistent with this subpart.

(ii) Provide that the group health plan will disclose protected health information to the plan sponsor only upon receipt of a certification by the plan sponsor that the plan documents have been amended to incorporate the following provisions and that the plan sponsor agrees to:

(A) Not use or further disclose the information other than as permitted or required by the plan documents or as required by law;

(B) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the group health plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information;

(C) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;

(D) Report to the group health plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(E) Make available protected health information in accordance with § 164.524;

(F) Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with § 164.526;

(G) Make available the information required to provide an accounting of disclosures in accordance with § 164.528;

(H) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the group health plan available to the Secretary for purposes of determining compliance by the group health plan with this subpart;

(I) If feasible, return or destroy all protected health information received from the group health plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(J) Ensure that the adequate separation required in paragraph (f)(2)(iii) of this section is established.

(iii) Provide for adequate separation between the group health plan and the plan sponsor. The plan
documents must:

(A) Describe those employees or classes of employees or other persons under the control of the plan sponsor to be given access to the protected health information to be disclosed, provided that any employee or person who receives protected health information relating to payment under, health care operations of, or other matters pertaining to the group health plan in the ordinary course of business must be included in such description;

(B) Restrict the access to and use by such employees and other persons described in paragraph (f)(2)(iii)(A) of this section to the plan administration functions that the plan sponsor performs for the group health plan; and

(C) Provide an effective mechanism for resolving any issues of noncompliance by persons described in paragraph (f)(2)(iii)(A) of this section with the plan document provisions required by this paragraph.

(3) Implementation specifications: Uses and disclosures. A group health plan may:

(i) Disclose protected health information to a plan sponsor to carry out plan administration functions that the plan sponsor performs only consistent with the provisions of paragraph (f)(2) of this section;

(ii) Not permit a health insurance issuer or HMO with respect to the group health plan to disclose protected health information to the plan sponsor except as permitted by this paragraph;

(iii) Not disclose and may not permit a health insurance issuer or HMO to disclose protected health information to a plan sponsor as otherwise permitted by this paragraph unless a statement required by § 164.520(b)(1)(iii)(C) is included in the appropriate notice; and

(iv) Not disclose protected health information to the plan sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

(g) Standard: Requirements for a covered entity with multiple covered functions.

(1) A covered entity that performs multiple covered functions that would make the entity any combination of a health plan, a covered health care provider, and a health care clearinghouse, must comply with the standards, requirements, and implementation specifications of this subpart, as applicable to the health plan, health care provider, or health care clearinghouse covered functions performed.

(2) A covered entity that performs multiple covered functions may use or disclose the protected health information of individuals who receive the covered entity's health plan or health care provider services, but not both, only for purposes related to the appropriate function being performed.

<General Materials (GM) - References, Annotations, or Tables>

END OF DOCUMENT
§ 164.506 Uses and disclosures to carry out treatment, payment, or health care operations.

(a) Standard: Permitted uses and disclosures. Except with respect to uses or disclosures that require an authorization under § 164.508(a)(2) and (3), a covered entity may use or disclose protected health information for treatment, payment, or health care operations as set forth in paragraph (c) of this section, provided that such use or disclosure is consistent with other applicable requirements of this subpart.

(b) Standard: Consent for uses and disclosures permitted.

   (1) A covered entity may obtain consent of the individual to use or disclose protected health information to carry out treatment, payment, or health care operations.

   (2) Consent, under paragraph (b) of this section, shall not be effective to permit a use or disclosure of protected health information when an authorization, under § 164.508, is required or when another condition must be met for such use or disclosure to be permissible under this subpart.

(c) Implementation specifications: Treatment, payment, or health care operations.

   (1) A covered entity may use or disclose protected health information for its own treatment, payment, or health care operations.

   (2) A covered entity may disclose protected health information for treatment activities of a health care provider.

   (3) A covered entity may disclose protected health information to another covered entity or a health care provider for the payment activities of the entity that receives the information.

   (4) A covered entity may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship, and the disclosure is:

      (i) For a purpose listed in paragraph (1) or (2) of the definition of health care operations; or

      (ii) For the purpose of health care fraud and abuse detection or compliance.

(5) A covered entity that participates in an organized health care arrangement may disclose protected health information about an individual to another covered entity that participates in the organized health care arrangement for any health care operations activities of the organized health care arrangement.

[67 FR 53268, Aug. 14, 2002]
§ 164.508 Uses and disclosures for which an authorization is required.

(a) Standard: authorizations for uses and disclosures.--

(1) Authorization required: general rule. Except as otherwise permitted or required by this subchapter, a covered entity may not use or disclose protected health information without an authorization that is valid under this section. When a covered entity obtains or receives a valid authorization for its use or disclosure of protected health information, such use or disclosure must be consistent with such authorization.

(2) Authorization required: psychotherapy notes. Notwithstanding any provision of this subpart, other than the transition provisions in § 164.532, a covered entity must obtain an authorization for any use or disclosure of psychotherapy notes, except:

(i) To carry out the following treatment, payment, or health care operations:

(A) Use by the originator of the psychotherapy notes for treatment;

(B) Use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or

(C) Use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual; and

(ii) A use or disclosure that is required by § 164.502(a)(2)(ii) or permitted by § 164.512(a); § 164.512(d) with respect to the oversight of the originator of the psychotherapy notes; § 164.512(g)(1); or § 164.512(j)(1)(i).

(3) Authorization required: Marketing.

(i) Notwithstanding any provision of this subpart, other than the transition provisions in § 164.532, a covered entity must obtain an authorization for any use or disclosure of protected health information for marketing, except if the communication is in the form of:

(A) A face-to-face communication made by a covered entity to an individual; or

(B) A promotional gift of nominal value provided by the covered entity.

(ii) If the marketing involves direct or indirect remuneration to the covered entity from a third party, the authorization must state that such remuneration is involved.

(b) Implementation specifications: general requirements.--

(1) Valid authorizations.

(i) A valid authorization is a document that meets the requirements in paragraphs (a)(3)(ii), (c)(1), and (c)(2) of this section, as applicable.

(ii) A valid authorization may contain elements or information in addition to the elements required by this section, provided that such additional elements or information are not inconsistent with the elements required by this section.

(2) Defective authorizations. An authorization is not valid, if the document submitted has any of the following defects:

(i) The expiration date has passed or the expiration event is known by the covered entity to have occurred;

(ii) The authorization has not been filled out completely, with respect to an element described by paragraph (c) of this section, if applicable;

(iii) The authorization is known by the covered entity to have been revoked;

(iv) The authorization violates paragraph (b)(3) or
(4) of this section, if applicable;

(v) Any material information in the authorization is known by the covered entity to be false.

(3) Compound authorizations. An authorization for use or disclosure of protected health information may not be combined with any other document to create a compound authorization, except as follows:

(i) An authorization for the use or disclosure of protected health information for a research study may be combined with any other type of written permission for the same research study, including another authorization for the use or disclosure of protected health information for such research or a consent to participate in such research;

(ii) An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes;

(iii) An authorization under this section, other than an authorization for a use or disclosure of psychotherapy notes, may be combined with any other such authorization under this section, except when a covered entity has conditioned the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits under paragraph (b)(4) of this section on the provision of one of the authorizations.

(4) Prohibition on conditioning of authorizations. A covered entity may not condition the provision to an individual of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization, except:

(i) A covered health care provider may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research under this section;

(ii) A health plan may condition enrollment in the health plan or eligibility for benefits on provision of an authorization requested by the health plan prior to an individual's enrollment in the health plan, if:

(A) The authorization sought is for the health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations; and

(B) The authorization is not for a use or disclosure of psychotherapy notes under paragraph (a)(2) of this section; and

(iii) A covered entity may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.

(5) Revocation of authorizations. An individual may revoke an authorization provided under this section at any time, provided that the revocation is in writing, except to the extent that:

(i) The covered entity has taken action in reliance thereon; or

(ii) If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

(6) Documentation. A covered entity must document and retain any signed authorization under this section as required by §164.530(j).

(c) Implementation specifications: Core elements and requirements.--

(1) Core elements. A valid authorization under this section must contain at least the following elements:

(i) A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.

(ii) The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.

(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure.

(iv) A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

(v) An expiration date or an expiration event that relates to the individual or the purpose of the use or
disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.

(vi) Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of such representative’s authority to act for the individual must also be provided.

(2) Required statements. In addition to the core elements, the authorization must contain statements adequate to place the individual on notice of all of the following:

(i) The individual's right to revoke the authorization in writing, and either:

(A) The exceptions to the right to revoke and a description of how the individual may revoke the authorization; or

(B) To the extent that the information in paragraph (c)(2)(i)(A) of this section is included in the notice required by § 164.520, a reference to the covered entity's notice.

(ii) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, by stating either:

(A) The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations in paragraph (b)(4) of this section applies; or

(B) The consequences to the individual of a refusal to sign the authorization when, in accordance with paragraph (b)(4) of this section, the covered entity can condition treatment, enrollment in the health plan, or eligibility for benefits on failure to obtain such authorization.

(iii) The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by this subpart.

(3) Plain language requirement. The authorization must be written in plain language.

(4) Copy to the individual. If a covered entity seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity must provide the individual with a copy of the signed authorization.

[67 FR 53268, Aug. 14, 2002]
A covered entity may use or disclose protected health information, provided that the individual is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the use or disclosure, in accordance with the applicable requirements of this section. The covered entity may orally inform the individual of and obtain the individual's oral agreement or objection to a use or disclosure permitted by this section.

(a) Standard: use and disclosure for facility directories.

(1) Permitted uses and disclosure. Except when an objection is expressed in accordance with paragraphs (a)(2) or (3) of this section, a covered health care provider may:

(i) Use the following protected health information to maintain a directory of individuals in its facility:

(A) The individual's name;

(B) The individual's location in the covered health care provider's facility;

(C) The individual's condition described in general terms that does not communicate specific medical information about the individual; and

(D) The individual's religious affiliation; and

(ii) Disclose for directory purposes such information:

(A) To members of the clergy; or

(B) Except for religious affiliation, to other persons who ask for the individual by name.

(2) Opportunity to object. A covered health care provider must inform an individual of the protected health information that it may include in a directory and the persons to whom it may disclose such information (including disclosures to clergy of information regarding religious affiliation) and provide the individual with the opportunity to restrict or prohibit some or all of the uses or disclosures permitted by paragraph (a)(1) of this section.

(3) Emergency circumstances.

(i) If the opportunity to object to uses or disclosures required by paragraph (a)(2) of this section cannot practicably be provided because of the individual's incapacity or an emergency treatment circumstance, a covered health care provider may use or disclose some or all of the protected health information permitted by paragraph (a)(1) of this section for the facility's directory, if such disclosure is:

(A) Consistent with a prior expressed preference of the individual, if any, that is known to the covered health care provider; and

(B) In the individual's best interest as determined by the covered health care provider, in the exercise of professional judgment.

(ii) The covered health care provider must inform the individual and provide an opportunity to object to uses or disclosures for directory purposes as required by paragraph (a)(2) of this section when it becomes practicable to do so.

(b) Standard: uses and disclosures for involvement in the individual's care and notification purposes.

(1) Permitted uses and disclosures.

(i) A covered entity may, in accordance with paragraphs (b)(2) or (3) of this section, disclose to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the protected
health information directly relevant to such person's involvement with the individual's care or payment related to the individual's health care.

(ii) A covered entity may use or disclose protected health information to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location, general condition, or death. Any such use or disclosure of protected health information for such notification purposes must be in accordance with paragraphs (b)(2), (3), or (4) of this section, as applicable.

(2) Uses and disclosures with the individual present. If the individual is present for, or otherwise available prior to, a use or disclosure permitted by paragraph (b)(1) of this section and has the capacity to make health care decisions, the covered entity may use or disclose the protected health information if it:

(i) Obtains the individual's agreement;

(ii) Provides the individual with the opportunity to object to the disclosure, and the individual does not express an objection; or

(iii) Reasonably infers from the circumstances, based the exercise of professional judgment, that the individual does not object to the disclosure.

(3) Limited uses and disclosures when the individual is not present. If the individual is not present, or the opportunity to agree or object to the use or disclosure cannot practically be provided because of the individual's incapacity or an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the person's involvement with the individual's health care. A covered entity may use professional judgment and its experience with common practice to make reasonable inferences of the individual's best interest in allowing a person to act on behalf of the individual to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

(4) Use and disclosures for disaster relief purposes. A covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures permitted by paragraph (b)(1)(ii) of this section. The requirements in paragraphs (b)(2) and (3) of this section apply to such uses and disclosure to the extent that the covered entity, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances.

[67 FR 53270, Aug. 14, 2002]


45 C. F. R. § 164.510, 45 CFR § 164.510

Current through February 12, 2010; 75 FR 6995

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END OF DOCUMENT
A covered entity may use or disclose protected health information without the written authorization of the individual, as described in § 164.508, or the opportunity for the individual to agree or object as described in § 164.510, in the situations covered by this section, subject to the applicable requirements of this section. When the covered entity is required by this section to inform the individual of, or when the individual may agree to, a use or disclosure permitted by this section, the covered entity's information and the individual's agreement may be given orally.

(a) Standard: Uses and disclosures required by law.

(1) A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

(2) A covered entity must meet the requirements described in paragraph (c), (e), or (f) of this section for uses or disclosures required by law.

(b) Standard: uses and disclosures for public health activities.

(1) Permitted disclosures. A covered entity may disclose protected health information for the public health activities and purposes described in this paragraph to:

(i) A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority;

(ii) A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

(iii) A person subject to the jurisdiction of the Food and Drug Administration (FDA) with respect to an FDA-regulated product or activity for which that person has responsibility, for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity. Such purposes include:

(A) To collect or report adverse events (or similar activities with respect to food or dietary supplements), product defects or problems (including problems with the use or labeling of a product), or biological product deviations;

(B) To track FDA-regulated products;

(C) To enable product recalls, repairs, or replacement, or lookback (including locating and notifying individuals who have received products that have been recalled, withdrawn, or are the subject of lookback); or

(D) To conduct post marketing surveillance;

(iv) A person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if the covered entity or public health authority is authorized by law to notify such person as necessary in the conduct of a public health intervention or investigation; or

(v) An employer, about an individual who is a member of the workforce of the employer, if:

(A) The covered entity is a covered health care provider who is a member of the workforce of such employer or who provides health care to the individual at the request of the employer:
(1) To conduct an evaluation relating to medical surveillance of the workplace; or

(2) To evaluate whether the individual has a work-related illness or injury;

(B) The protected health information that is disclosed consists of findings concerning a work-related illness or injury or a workplace-related medical surveillance;

(C) The employer needs such findings in order to comply with its obligations, under 29 CFR parts 1904 through 1928, 30 CFR parts 50 through 90, or under state law having a similar purpose, to record such illness or injury or to carry out responsibilities for workplace medical surveillance; and

(D) The covered health care provider provides written notice to the individual that protected health information relating to the medical surveillance of the workplace and work-related illnesses and injuries is disclosed to the employer:

(1) By giving a copy of the notice to the individual at the time the health care is provided; or

(2) If the health care is provided on the work site of the employer, by posting the notice in a prominent place at the location where the health care is provided.

(2) Permitted uses. If the covered entity also is a public health authority, the covered entity is permitted to use protected health information in all cases in which it is permitted to disclose such information for public health activities under paragraph (b)(1) of this section.

(c) Standard: Disclosures about victims of abuse, neglect or domestic violence.

(1) Permitted disclosures. Except for reports of child abuse or neglect permitted by paragraph (b)(1)(ii) of this section, a covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:

(i) To the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law;

(ii) If the individual agrees to the disclosure; or

(iii) To the extent the disclosure is expressly authorized by statute or regulation and:

(A) The covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims; or

(B) If the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

(2) Informing the individual. A covered entity that makes a disclosure permitted by paragraph (c)(1) of this section must promptly inform the individual that such a report has been or will be made, except if:

(i) The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

(d) Standard: Uses and disclosures for health oversight activities.
45 CFR § 164.512

(1) Permitted disclosures. A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight:

(i) The health care system;

(ii) Government benefit programs for which health information is relevant to beneficiary eligibility;

(iii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or

(iv) Entities subject to civil rights laws for which health information is necessary for determining compliance.

(2) Exception to health oversight activities. For the purpose of the disclosures permitted by paragraph (d)(1) of this section, a health oversight activity does not include an investigation or other activity in which the individual is the subject of the investigation or activity and such investigation or other activity does not arise out of and is not directly related to:

(i) The receipt of health care;

(ii) A claim for public benefits related to health; or

(iii) Qualification for, or receipt of, public benefits or services when a patient's health is integral to the claim for public benefits or services.

(3) Joint activities or investigations. Notwithstanding paragraph (d)(2) of this section, if a health oversight activity or investigation is conducted in conjunction with an oversight activity or investigation relating to a claim for public benefits not related to health, the joint activity or investigation is considered a health oversight activity for purposes of paragraph (d) of this section.

(4) Permitted uses. If a covered entity also is a health oversight agency, the covered entity may use protected health information for health oversight activities as permitted by paragraph (d) of this section.

(e) Standard: Disclosures for judicial and administrative proceedings.

(1) Permitted disclosures. A covered entity may disclose protected health information in the course of any judicial or administrative proceeding:

(i) In response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order; or

(ii) In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if:

(A) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iii) of this section, from the party seeking the information that reasonable efforts have been made by such party to ensure that the individual who is the subject of the protected health information that has been requested has been given notice of the request; or

(B) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iv) of this section, from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order that meets the requirements of paragraph (e)(1)(v) of this section.

(iii) For the purposes of paragraph (e)(1)(ii)(A) of this section, a covered entity receives satisfactory assurances from a party seeking protecting health information if the covered entity receives from such party a written statement and accompanying documentation demonstrating that:

(A) The party requesting such information has made a good faith attempt to provide written notice to the individual (or, if the
individual's location is unknown, to mail a notice to the individual's last known address; (B) The notice included sufficient information about the litigation or proceeding in which the protected health information is requested to permit the individual to raise an objection to the court or administrative tribunal; and (C) The time for the individual to raise objections to the court or administrative tribunal has elapsed, and:

(1) No objections were filed; or

(2) All objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.

(iv) For the purposes of paragraph (e)(1)(ii)(B) of this section, a covered entity receives satisfactory assurances from a party seeking protected health information, if the covered entity receives from such party a written statement and accompanying documentation demonstrating that:

(A) The parties to the dispute giving rise to the request for information have agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or

(B) The party seeking the protected health information has requested a qualified protective order from such court or administrative tribunal.

(v) For purposes of paragraph (e)(1) of this section, a qualified protective order means, with respect to protected health information requested under paragraph (e)(1)(ii) of this section, an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that:

(A) Prohibits the parties from using or disclosing the protected health information for any purpose other than the litigation or proceeding for which such information was requested; and (B) Requires the return to the covered entity or destruction of the protected health information (including all copies made) at the end of the litigation or proceeding.

(vi) Notwithstanding paragraph (e)(1)(ii) of this section, a covered entity may disclose protected health information in response to lawful process described in paragraph (e)(1)(ii) of this section without receiving satisfactory assurance under paragraph (e)(1)(ii)(A) or (B) of this section, if the covered entity makes reasonable efforts to provide notice to the individual sufficient to meet the requirements of paragraph (e)(1)(iii) of this section or to seek a qualified protective order sufficient to meet the requirements of paragraph (e)(1)(iv) of this section.

(2) Other uses and disclosures under this section. The provisions of this paragraph do not supersede other provisions of this section that otherwise permit or restrict uses or disclosures of protected health information.

(f) Standard: Disclosures for law enforcement purposes. A covered entity may disclose protected health information for a law enforcement purpose to a law enforcement official if the conditions in paragraphs (f)(1) through (f)(6) of this section are met, as applicable.

(1) Permitted disclosures: Pursuant to process and as otherwise required by law. A covered entity may disclose protected health information:

(i) As required by law including laws that require the reporting of certain types of wounds or other physical injuries, except for laws subject to paragraphs (b)(1)(ii) or (c)(1)(i) of this section; or

(ii) In compliance with and as limited by the relevant requirements of:

(A) A court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer; (B) A grand jury subpoena; or

(C) An administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:
(1) The information sought is relevant and material to a legitimate law enforcement inquiry;

(2) The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and

(3) De-identified information could not reasonably be used.

(2) Permitted disclosures: Limited information for identification and location purposes. Except for disclosures required by law as permitted by paragraph (f)(1) of this section, a covered entity may disclose protected health information in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, provided that:

(i) The covered entity may disclose only the following information:

(A) Name and address;

(B) Date and place of birth;

(C) Social security number;

(D) ABO blood type and rh factor;

(E) Type of injury;

(F) Date and time of treatment;

(G) Date and time of death, if applicable; and

(H) A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

(ii) Except as permitted by paragraph (f)(2)(i) of this section, the covered entity may not disclose for the purposes of identification or location under paragraph (f)(2) of this section any protected health information related to the individual's DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue.

(3) Permitted disclosure: Victims of a crime. Except for disclosures required by law as permitted by paragraph (f)(1) of this section, a covered entity may disclose protected health information in response to a law enforcement official's request for such information about an individual who is or is suspected to be a victim of a crime, other than disclosures that are subject to paragraph (b) or (c) of this section, if:

(i) The individual agrees to the disclosure; or

(ii) The covered entity is unable to obtain the individual's agreement because of incapacity or other emergency circumstance, provided that:

(A) The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim;

(B) The law enforcement official represents that immediate law enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure; and

(C) The disclosure is in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

(4) Permitted disclosure: Decedents. A covered entity may disclose protected health information about an individual who has died to a law enforcement official for the purpose of alerting law enforcement of the death of the individual if the covered entity has a suspicion that such death may have resulted from criminal conduct.

(5) Permitted disclosure: Crime on premises. A covered entity may disclose to a law enforcement official protected health information that the covered entity believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the covered entity.

(6) Permitted disclosure: Reporting crime in emergencies.
(i) A covered health care provider providing emergency health care in response to a medical emergency, other than such emergency on the premises of the covered health care provider, may disclose protected health information to a law enforcement official if such disclosure appears necessary to alert law enforcement to:

(A) The commission and nature of a crime;
(B) The location of such crime or of the victim(s) of such crime; and
(C) The identity, description, and location of the perpetrator of such crime.

(ii) If a covered health care provider believes that the medical emergency described in paragraph (f)(6)(i) of this section is the result of abuse, neglect, or domestic violence of the individual in need of emergency health care, paragraph (f)(6)(i) of this section does not apply and any disclosure to a law enforcement official for law enforcement purposes is subject to paragraph (c) of this section.

(g) Standard: Uses and disclosures about decedents.

(1) Coroners and medical examiners. A covered entity may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. A covered entity that also performs the duties of a coroner or medical examiner may use protected health information for the purposes described in this paragraph.

(2) Funeral directors. A covered entity may disclose protected health information to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. If necessary for funeral directors to carry out their duties, the covered entity may disclose the protected health information prior to, and in reasonable anticipation of, the individual’s death.

(h) Standard: Uses and disclosures for cadaveric organ, eye or tissue donation purposes. A covered entity may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

(i) Standard: Uses and disclosures for research purposes.

(1) Permitted uses and disclosures. A covered entity may use or disclose protected health information for research, regardless of the source of funding of the research, provided that:

(i) Board approval of a waiver of authorization. The covered entity obtains documentation that an alteration to or waiver, in whole or in part, of the individual authorization required by § 164.508 for use or disclosure of protected health information has been approved by either:


(B) A privacy board that:

(1) Has members with varying backgrounds and appropriate professional competency as necessary to review the effect of the research protocol on the individual’s privacy rights and related interests;
(2) Includes at least one member who is not affiliated with the covered entity, not affiliated with any entity conducting or sponsoring the research, and not related to any person who is affiliated with any of such entities; and
(3) Does not have any member participating in a review of any project in which the member has a conflict of interest.

(ii) Reviews preparatory to research. The covered entity obtains from the researcher representations that:

(A) Use or disclosure is sought solely to review protected health information as necessary to prepare a research protocol or
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for similar purposes preparatory to research;

(B) No protected health information is to be removed from the covered entity by the researcher in the course of the review; and

(C) The protected health information for which use or access is sought is necessary for the research purposes.

(iii) Research on decedent's information. The covered entity obtains from the researcher:

(A) Representation that the use or disclosure sought is solely for research on the protected health information of decedents;

(B) Documentation, at the request of the covered entity, of the death of such individuals; and

(C) Representation that the protected health information for which use or disclosure is sought is necessary for the research purposes.

(2) Documentation of waiver approval. For a use or disclosure to be permitted based on documentation of approval of an alteration or waiver, under paragraph (i)(1)(i) of this section, the documentation must include all of the following:

(i) Identification and date of action. A statement identifying the IRB or privacy board and the date on which the alteration or waiver of authorization was approved;

(ii) Waiver criteria. A statement that the IRB or privacy board has determined that the alteration or waiver, in whole or in part, of authorization satisfies the following criteria:

(A) The use or disclosure of protected health information involves no more than a minimal risk to the privacy of individuals, based on, at least, the presence of the following elements:

(1) An adequate plan to protect the identifiers from improper use and disclosure;

(2) An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law; and

(3) Adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research study, or for other research for which the use or disclosure of protected health information would be permitted by this subpart;

(B) The research could not practicably be conducted without the waiver or alteration; and

(C) The research could not practicably be conducted without access to and use of the protected health information.

(iii) Protected health information needed. A brief description of the protected health information for which use or access has been determined to be necessary by the IRB or privacy board has determined, pursuant to paragraph (i)(2)(ii)(C) of this section;

(iv) Review and approval procedures. A statement that the alteration or waiver of authorization has been reviewed and approved under either normal or expedited review procedures, as follows:

(B) A privacy board must review the proposed research at convened meetings at which a majority of the privacy board members are present, including at least one member who satisfies the criterion stated in paragraph (i)(1)(i)(B)(2) of this section, and the alteration or waiver of authorization must be approved by the majority of the privacy board members present at the meeting, unless the privacy board elects to use an expedited review procedure in accordance with paragraph (i)(2)(iv)(C) of this section;

(C) A privacy board may use an expedited review procedure if the research involves no more than minimal risk to the privacy of the individuals who are the subject of the protected health information for which use or disclosure is being sought. If the privacy board elects to use an expedited review procedure, the review and approval of the alteration or waiver of authorization may be carried out by the chair of the privacy board, or by one or more members of the privacy board as designated by the chair; and

(v) Required signature. The documentation of the alteration or waiver of authorization must be signed by the chair or other member, as designated by the chair, of the IRB or the privacy board, as applicable.

(j) Standard: Uses and disclosures to avert a serious threat to health or safety.

(1) Permitted disclosures. A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure:

(i)(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and

(B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or

(ii) Is necessary for law enforcement authorities to identify or apprehend an individual:

(A) Because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim; or

(B) Where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody, as those terms are defined in § 164.501.

(2) Use or disclosure not permitted. A use or disclosure pursuant to paragraph (j)(1)(ii)(A) of this section may not be made if the information described in paragraph (j)(1)(ii)(A) of this section is learned by the covered entity:

(i) In the course of treatment to affect the propensity to commit the criminal conduct that is the basis for the disclosure under paragraph (j)(1)(ii)(A) of this section, or counseling or therapy; or

(ii) Through a request by the individual to initiate or to be referred for the treatment, counseling, or therapy described in paragraph (j)(2)(i) of this section.

(3) Limit on information that may be disclosed. A disclosure made pursuant to paragraph (j)(1)(ii)(A) of this section shall contain only the statement described in paragraph (j)(1)(ii)(A) of this section and the protected health information described in paragraph (f)(2)(i) of this section.

(4) Presumption of good faith belief. A covered entity that uses or discloses protected health information pursuant to paragraph (j)(1) of this section is presumed to have acted in good faith with regard to a belief described in paragraph (j)(1)(i) or (ii) of this section, if the belief is based upon the covered entity's actual knowledge or in reliance on a credible representation by a person with apparent knowledge or authority.

(k) Standard: Uses and disclosures for specialized government functions.

(1) Military and veterans activities.

(i) Armed Forces personnel. A covered entity may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to
assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register the following information:

(A) Appropriate military command authorities; and

(B) The purposes for which the protected health information may be used or disclosed.

(ii) Separation or discharge from military service. A covered entity that is a component of the Departments of Defense or Transportation may disclose to the Department of Veterans Affairs (DVA) the protected health information of an individual who is a member of the Armed Forces upon the separation or discharge of the individual from military service for the purpose of a determination by DVA of the individual's eligibility for or entitlement to benefits under laws administered by the Secretary of Veterans Affairs.

(iii) Veterans. A covered entity that is a component of the Department of Veterans Affairs may use and disclose protected health information to components of the Department that determine eligibility for or entitlement to, or that provide, benefits under the laws administered by the Secretary of Veterans Affairs.

(iv) Foreign military personnel. A covered entity may use and disclose the protected health information of individuals who are foreign military personnel to their appropriate foreign military authority for the same purposes for which uses and disclosures are permitted for Armed Forces personnel under the notice published in the Federal Register pursuant to paragraph (k)(1)(i) of this section.

(2) National security and intelligence activities. A covered entity may disclose protected health information to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act (50 U.S.C. 401, et seq.) and implementing authority (e.g., Executive Order 12333).

(3) Protective services for the President and others. A covered entity may disclose protected health information to authorized federal officials for the provision of protective services to the President or other persons authorized by 18 U.S.C. 3056, or to foreign heads of state or other persons authorized by 22 U.S.C. 2709(a)(3), or to for the conduct of investigations authorized by 18 U.S.C. 871 and 879.

(4) Medical suitability determinations. A covered entity that is a component of the Department of State may use protected health information to make medical suitability determinations and may disclose whether or not the individual was determined to be medically suitable to the officials in the Department of State who need access to such information for the following purposes:

(i) For the purpose of a required security clearance conducted pursuant to Executive Orders 10450 and 12698;

(ii) As necessary to determine worldwide availability or availability for mandatory service abroad under sections 101(a)(4) and 504 of the Foreign Service Act; or

(iii) For a family to accompany a Foreign Service member abroad, consistent with section 101(b)(5) and 904 of the Foreign Service Act.

(5) Correctional institutions and other law enforcement custodial situations.

(i) Permitted disclosures. A covered entity may disclose to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual protected health information about such inmate or individual, if the correctional institution or such law enforcement official represents that such protected health information is necessary for:

(A) The provision of health care to such individuals;

(B) The health and safety of such individual or other inmates;

(C) The health and safety of the officers or employees of or others at the correctional institution;

(D) The health and safety of such individuals and officers or other persons responsible for the transporting of inmates.
or their transfer from one institution, facility, or setting to another;

(E) Law enforcement on the premises of the correctional institution; and

(F) The administration and maintenance of the safety, security, and good order of the correctional institution.

(ii) Permitted uses. A covered entity that is a correctional institution may use protected health information of individuals who are inmates for any purpose for which such protected health information may be disclosed.

(iii) No application after release. For the purposes of this provision, an individual is no longer an inmate when released on parole, probation, supervised release, or otherwise is no longer in lawful custody.

(6) Covered entities that are government programs providing public benefits.

(i) A health plan that is a government program providing public benefits may disclose protected health information relating to eligibility for or enrollment in the health plan to another agency administering a government program providing public benefits if the sharing of eligibility or enrollment information among such government agencies or the maintenance of such information in a single or combined data system accessible to all such government agencies is required or expressly authorized by statute or regulation.

(ii) A covered entity that is a government agency administering a government program providing public benefits may disclose protected health information relating to the program to another covered entity that is a government agency administering a government program providing public benefits if the programs serve the same or similar populations and the disclosure of protected health information is necessary to coordinate the covered functions of such programs or to improve administration and management relating to the covered functions of such programs.

(l) Standard: Disclosures for workers' compensation. A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

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45 CFR § 164.520

**Effective:** [See Text Amendments]

45 CFR § 164.520

Notice of privacy practices for protected health information.

(a) Standard: notice of privacy practices--

(1) Right to notice. Except as provided by paragraph (a)(2) or (3) of this section, an individual has a right to adequate notice of the uses and disclosures of protected health information that may be made by the covered entity, and of the individual's rights and the covered entity's legal duties with respect to protected health information.

(2) Exception for group health plans.

(i) An individual enrolled in a group health plan has a right to notice:

(A) From the group health plan, if, and to the extent that, such an individual does not receive health benefits under the group health plan through an insurance contract with a health insurance issuer or HMO; or

(B) From the health insurance issuer or HMO with respect to the group health plan through which such individuals receive their health benefits under the group health plan.

(ii) A group health plan that provides health benefits solely through an insurance contract with a health insurance issuer or HMO, and that creates or receives protected health information in addition to summary health information as defined in § 164.504(a) or information on whether an individual is participating in the group health plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the plan, must:

(A) Maintain a notice under this section; and

(B) Provide such notice upon request to any person. The provisions of paragraph (c)(1) of this section do not apply to such group health plan.

(iii) A group health plan that provides health benefits solely through an insurance contract with a health insurance issuer or HMO, and does not create or receive protected health information other than summary health information as defined in § 164.504(a) or information on whether an individual is participating in the group health plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the plan, is not required to maintain or provide a notice under this section.

(3) Exception for inmates. An inmate does not have a right to notice under this section, and the requirements of this section do not apply to a correctional institution that is a covered entity.

(b) Implementation specifications: content of notice--

(1) Required elements. The covered entity must provide a notice that is written in plain language and that contains the elements required by this paragraph.

(i) Header. The notice must contain the following statement as a header or otherwise prominently displayed: “THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.”

(ii) Uses and disclosures. The notice must contain:

(A) A description, including at least one example, of the types of uses and disclosures that the covered entity is permitted by this subpart to make for each of the following purposes: treatment, payment, and health care operations.

(B) A description of each of the other purposes for which the covered entity is
permitted or required by this subpart to use or disclose protected health information without the individual's written authorization.

(C) If a use or disclosure for any purpose described in paragraphs (b)(1)(ii)(A) or (B) of this section is prohibited or materially limited by other applicable law, the description of such use or disclosure must reflect the more stringent law as defined in § 160.202 of this subchapter.

(D) For each purpose described in paragraph (b)(1)(ii)(A) or (B) of this section, the description must include sufficient detail to place the individual on notice of the uses and disclosures that are permitted or required by this subpart and other applicable law.

(E) A statement that other uses and disclosures will be made only with the individual's written authorization and that the individual may revoke such authorization as provided by § 164.508(b)(5).

(iii) Separate statements for certain uses or disclosures. If the covered entity intends to engage in any of the following activities, the description required by paragraph (b)(1)(ii)(A) of this section must include a separate statement, as applicable, that:

(A) The covered entity may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual;

(B) The covered entity may contact the individual to raise funds for the covered entity; or

(C) A group health plan, or a health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the sponsor of the plan.

(iv) Individual rights. The notice must contain a statement of the individual's rights with respect to protected health information and a brief description of how the individual may exercise these rights, as follows:

(A) The right to request restrictions on certain uses and disclosures of protected health information as provided by § 164.522(a), including a statement that the covered entity is not required to agree to a requested restriction;

(B) The right to receive confidential communications of protected health information as provided by § 164.522(b), as applicable;

(C) The right to inspect and copy protected health information as provided by § 164.524;

(D) The right to amend protected health information as provided by § 164.526;

(E) The right to receive an accounting of disclosures of protected health information as provided by § 164.528; and

(F) The right of an individual, including an individual who has agreed to receive the notice electronically in accordance with paragraph (c)(3) of this section, to obtain a paper copy of the notice from the covered entity upon request.

(v) Covered entity's duties. The notice must contain:

(A) A statement that the covered entity is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information;

(B) A statement that the covered entity is required to abide by the terms of the notice currently in effect; and

(C) For the covered entity to apply a change in a privacy practice that is described in the notice to protected health information that the covered entity created or received prior to issuing a revised notice, in accordance with § 164.530(i)(2)(ii), a statement that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health
information that it maintains. The statement must also describe how it will provide individuals with a revised notice.

(vi) Complaints. The notice must contain a statement that individuals may complain to the covered entity and to the Secretary if they believe their privacy rights have been violated, a brief description of how the individual may file a complaint with the covered entity, and a statement that the individual will not be retaliated against for filing a complaint.

(vii) Contact. The notice must contain the name, or title, and telephone number of a person or office to contact for further information as required by § 164.530(a)(1)(ii).

(viii) Effective date. The notice must contain the date on which the notice is first in effect, which may not be earlier than the date on which the notice is printed or otherwise published.

(2) Optional elements.

(i) In addition to the information required by paragraph (b)(1) of this section, if a covered entity elects to limit the uses or disclosures that it is permitted to make under this subpart, the covered entity may describe its more limited uses or disclosures in its notice, provided that the covered entity may not include in its notice a limitation affecting its right to make a use or disclosure that is required by law or permitted by § 164.512(j)(1)(i).

(ii) For the covered entity to apply a change in its more limited uses and disclosures to protected health information created or received prior to issuing a revised notice, in accordance with § 164.530(i)(2)(ii), the notice must include the statements required by paragraph (b)(1)(v)(C) of this section.

(3) Revisions to the notice. The covered entity must promptly revise and distribute its notice whenever there is a material change to the uses or disclosures, the individual's rights, the covered entity's legal duties, or other privacy practices stated in the notice. Except when required by law, a material change to any term of the notice may not be implemented prior to the effective date of the notice in which such material change is reflected.

(c) Implementation specifications: Provision of notice. A covered entity must make the notice required by this section available on request to any person and to individuals as specified in paragraphs (c)(1) through (c)(3) of this section, as applicable.

(1) Specific requirements for health plans.

(i) A health plan must provide notice:

(A) No later than the compliance date for the health plan, to individuals then covered by the plan;

(B) Thereafter, at the time of enrollment, to individuals who are new enrollees; and

(C) Within 60 days of a material revision to the notice, to individuals then covered by the plan.

(ii) No less frequently than once every three years, the health plan must notify individuals then covered by the plan of the availability of the notice and how to obtain the notice.

(iii) The health plan satisfies the requirements of paragraph (c)(1) of this section if notice is provided to the named insured of a policy under which coverage is provided to the named insured and one or more dependents.

(iv) If a health plan has more than one notice, it satisfies the requirements of paragraph (c)(1) of this section by providing the notice that is relevant to the individual or other person requesting the notice.

(2) Specific requirements for certain covered health care providers. A covered health care provider that has a direct treatment relationship with an individual must:

(i) Provide the notice:

(A) No later than the date of the first service delivery, including service delivered electronically, to such individual after the compliance date for the covered health care provider; or

(B) In an emergency treatment situation, as soon as reasonably practicable after the emergency treatment situation.
(ii) Except in an emergency treatment situation, make a good faith effort to obtain a written acknowledgment of receipt of the notice provided in accordance with paragraph (c)(2)(i) of this section, and if not obtained, document its good faith efforts to obtain such acknowledgment and the reason why the acknowledgment was not obtained;

(iii) If the covered health care provider maintains a physical service delivery site:

(A) Have the notice available at the service delivery site for individuals to request to take with them; and

(B) Post the notice in a clear and prominent location where it is reasonable to expect individuals seeking service from the covered health care provider to be able to read the notice; and

(iv) Whenever the notice is revised, make the notice available upon request on or after the effective date of the revision and promptly comply with the requirements of paragraph (c)(2)(iii) of this section, if applicable.

(3) Specific requirements for electronic notice.

(i) A covered entity that maintains a web site that provides information about the covered entity's customer services or benefits must prominently post its notice on the web site and make the notice available electronically through the web site.

(ii) A covered entity may provide the notice required by this section to an individual by e-mail, if the individual agrees to electronic notice and such agreement has not been withdrawn. If the covered entity knows that the e-mail transmission has failed, a paper copy of the notice must be provided to the individual. Provision of electronic notice by the covered entity will satisfy the provision requirements of paragraph (c) of this section when timely made in accordance with paragraph (c)(1) or (2) of this section.

(iii) For purposes of paragraph (c)(2)(i) of this section, if the first service delivery to an individual is delivered electronically, the covered health care provider must provide electronic notice automatically and contemporaneously in response to the individual's first request for service. The requirements in paragraph (c)(2)(ii) of this section apply to electronic notice.

(iv) The individual who is the recipient of electronic notice retains the right to obtain a paper copy of the notice from a covered entity upon request.

(d) Implementation specifications: Joint notice by separate covered entities. Covered entities that participate in organized health care arrangements may comply with this section by a joint notice, provided that:

(1) The covered entities participating in the organized health care arrangement agree to abide by the terms of the notice with respect to protected health information created or received by the covered entity as part of its participation in the organized health care arrangement;

(2) The joint notice meets the implementation specifications in paragraph (b) of this section, except that the statements required by this section may be altered to reflect the fact that the notice covers more than one covered entity; and

(i) Describes with reasonable specificity the covered entities, or class of entities, to which the joint notice applies;

(ii) Describes with reasonable specificity the service delivery sites, or classes of service delivery sites, to which the joint notice applies; and

(iii) If applicable, states that the covered entities participating in the organized health care arrangement will share protected health information with each other, as necessary to carry out treatment, payment, or health care operations relating to the organized health care arrangement.

(3) The covered entities included in the joint notice must provide the notice to individuals in accordance with the applicable implementation specifications of paragraph (c) of this section. Provision of the joint notice to an individual by any one of the covered entities included in the joint notice will satisfy the provision requirement of paragraph (c) of this section with respect to all others covered by the joint notice.
(e) Implementation specifications: Documentation. A covered entity must document compliance with the notice requirements, as required by § 164.530(j), by retaining copies of the notices issued by the covered entity and, if applicable, any written acknowledgments of receipt of the notice or documentation of good faith efforts to obtain such written acknowledgment, in accordance with paragraph (c)(2)(ii) of this section.

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§ 164.524 Access of individuals to protected health information.

(a) Standard: Access to protected health information.

(1) Right of access. Except as otherwise provided in paragraph (a)(2) or (a)(3) of this section, an individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set, for as long as the protected health information is maintained in the designated record set, except for:

(i) Psychotherapy notes;

(ii) Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and

(iii) Protected health information maintained by a covered entity that is:

(A) Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a, to the extent the provision of access to the individual would be prohibited by law; or

(B) Exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2).

(2) Unreviewable grounds for denial. A covered entity may deny an individual access without providing the individual an opportunity for review, in the following circumstances.

(i) The protected health information is excepted from the right of access by paragraph (a)(1) of this section.

(ii) A covered entity that is a correctional institution or a covered health care provider acting under the direction of the correctional institution may deny, in whole or in part, an inmate's request to obtain a copy of protected health information, if obtaining such copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for the transporting of the inmate.

(iii) An individual's access to protected health information created or obtained by a covered health care provider in the course of research that includes treatment may be temporarily suspended for as long as the research is in progress, provided that the individual has agreed to the denial of access when consenting to participate in the research that includes treatment, and the covered health care provider has informed the individual that the right of access will be reinstated upon completion of the research.

(iv) An individual's access to protected health information that is contained in records that are subject to the Privacy Act, 5 U.S.C. 552a, may be denied, if the denial of access under the Privacy Act would meet the requirements of that law.

(v) An individual's access may be denied if the protected health information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

(3) Reviewable grounds for denial. A covered entity may deny an individual access, provided that the individual is given a right to have such denials reviewed, as required by paragraph (a)(4) of this section, in the following circumstances:

(i) A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person;

(ii) The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such
other person; or

(iii) The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

(4) Review of a denial of access. If access is denied on a ground permitted under paragraph (a)(3) of this section, the individual has the right to have the denial reviewed by a licensed health care professional who is designated by the covered entity to act as a reviewing official and who did not participate in the original decision to deny. The covered entity must provide or deny access in accordance with the determination of the reviewing official under paragraph (d)(4) of this section.

(b) Implementation specifications: requests for access and timely action.

(1) Individual's request for access. The covered entity must permit an individual to request access to inspect or to obtain a copy of the protected health information about the individual that is maintained in a designated record set. The covered entity may require individuals to make requests for access in writing, provided that it informs individuals of such a requirement.

(2) Timely action by the covered entity.

(i) Except as provided in paragraph (b)(2)(ii) of this section, the covered entity must act on a request for access no later than 30 days after receipt of the request as follows.

(A) If the covered entity grants the request, in whole or in part, it must inform the individual of the acceptance of the request and provide the access requested, in accordance with paragraph (c) of this section.

(B) If the covered entity denies the request, in whole or in part, it must provide the individual with a written denial, in accordance with paragraph (d) of this section.

(ii) If the request for access is for protected health information that is not maintained or accessible to the covered entity on-site, the covered entity must take an action required by paragraph (b)(2)(i) of this section by no later than 60 days from the receipt of such a request.

(iii) If the covered entity is unable to take an action required by paragraph (b)(2)(i)(A) or (B) of this section within the time required by paragraph (b)(2)(i) or (ii) of this section, as applicable, the covered entity may extend the time for such actions by no more than 30 days, provided that:

(A) The covered entity, within the time limit set by paragraph (b)(2)(i) or (ii) of this section, as applicable, provides the individual with a written statement of the reasons for the delay and the date by which the covered entity will complete its action on the request; and

(B) The covered entity may have only one such extension of time for action on a request for access.

(c) Implementation specifications: Provision of access. If the covered entity provides an individual with access, in whole or in part, to protected health information, the covered entity must comply with the following requirements.

(1) Providing the access requested. The covered entity must provide the access requested by individuals, including inspection or obtaining a copy, or both, of the protected health information about them in designated record sets. If the same protected health information that is the subject of a request for access is maintained in more than one designated record set or at more than one location, the covered entity need only produce the protected health information once in response to a request for access.

(2) Form of access requested.

(i) The covered entity must provide the individual with access to the protected health information in the form or format requested by the individual, if it is readily producible in such form or format; or, if not, in a readable hard copy form or such other form or format as agreed to by the covered entity and the individual.

(ii) The covered entity may provide the individual with a summary of the protected health information requested, in lieu of providing access to the protected health information or may provide an explanation of the protected health information to which access has been provided, if:

(A) The individual agrees in advance to such a summary or explanation; and
(B) The individual agrees in advance to the fees imposed, if any, by the covered entity for such summary or explanation.

(3) Time and manner of access. The covered entity must provide the access as requested by the individual in a timely manner as required by paragraph (b)(2) of this section, including arranging with the individual for a convenient time and place to inspect or obtain a copy of the protected health information, or mailing the copy of the protected health information at the individual's request. The covered entity may discuss the scope, format, and other aspects of the request for access with the individual as necessary to facilitate the timely provision of access.

(4) Fees. If the individual requests a copy of the protected health information or agrees to a summary or explanation of such information, the covered entity may impose a reasonable, cost-based fee, provided that the fee includes only the cost of:

(i) Copying, including the cost of supplies for and labor of copying, the protected health information requested by the individual;

(ii) Postage, when the individual has requested the copy, or the summary or explanation, be mailed; and

(iii) Preparing an explanation or summary of the protected health information, if agreed to by the individual as required by paragraph (c)(2)(ii) of this section.

(d) Implementation specifications: Denial of access. If the covered entity denies access, in whole or in part, to protected health information, the covered entity must comply with the following requirements.

(1) Making other information accessible. The covered entity must, to the extent possible, give the individual access to any other protected health information requested, after excluding the protected health information as to which the covered entity has a ground to deny access.

(2) Denial. The covered entity must provide a timely, written denial to the individual, in accordance with paragraph (b)(2) of this section. The denial must be in plain language and contain:

(i) The basis for the denial;

(ii) If applicable, a statement of the individual's review rights under paragraph (a)(4) of this section, including a description of how the individual may exercise such review rights; and

(iii) A description of how the individual may complain to the covered entity pursuant to the complaint procedures in § 164.530(d) or to the Secretary pursuant to the procedures in § 160.306. The description must include the name, or title, and telephone number of the contact person or office designated in § 164.530(a)(1)(ii).

(3) Other responsibility. If the covered entity does not maintain the protected health information that is the subject of the individual's request for access, and the covered entity knows where the requested information is maintained, the covered entity must inform the individual where to direct the request for access.

(4) Review of denial requested. If the individual has requested a review of a denial under paragraph (a)(4) of this section, the covered entity must designate a licensed health care professional, who was not directly involved in the denial to review the decision to deny access. The covered entity must promptly refer a request for review to such designated reviewing official. The designated reviewing official must determine, within a reasonable period of time, whether or not to deny the access requested based on the standards in paragraph (a)(3) of this section. The covered entity must promptly provide written notice to the individual of the determination of the designated reviewing official and take other action as required by this section to carry out the designated reviewing official's determination.

(e) Implementation specification: Documentation. A covered entity must document the following and retain the documentation as required by § 164.530(j):

(1) The designated record sets that are subject to access by individuals; and

(2) The titles of the persons or offices responsible for receiving and processing requests for access by individuals.

<General Materials (GM) - References, Annotations, or Tables>
§ 164.528 Accounting of disclosures of protected health information.

(a) Standard: Right to an accounting of disclosures of protected health information.

(1) An individual has a right to receive an accounting of disclosures of protected health information made by a covered entity in the six years prior to the date on which the accounting is requested, except for disclosures:

(i) To carry out treatment, payment and health care operations as provided in § 164.506;

(ii) To individuals of protected health information about them as provided in § 164.502;

(iii) Incident to a use or disclosure otherwise permitted or required by this subpart, as provided in § 164.502;

(iv) Pursuant to an authorization as provided in § 164.508;

(v) For the facility's directory or to persons involved in the individual's care or other notification purposes as provided in § 164.510;

(vi) For national security or intelligence purposes as provided in § 164.512(k)(2);

(vii) To correctional institutions or law enforcement officials as provided in § 164.512(k)(5);

(viii) As part of a limited data set in accordance with § 164.514(e); or

(ix) That occurred prior to the compliance date for the covered entity.

(2)(i) The covered entity must temporarily suspend an individual's right to receive an accounting of disclosures to a health oversight agency or law enforcement official, as provided in § 164.512(d) or (f), respectively, for the time specified by such agency or official, if such agency or official provides the covered entity with a written statement that such an accounting to the individual would be reasonably likely to impede the agency's activities and specifying the time for which such a suspension is required.

(ii) If the agency or official statement in paragraph (a)(2)(i) of this section is made orally, the covered entity must:

(A) Document the statement, including the identity of the agency or official making the statement;

(B) Temporarily suspend the individual's right to an accounting of disclosures subject to the statement; and

(C) Limit the temporary suspension to no longer than 30 days from the date of the oral statement, unless a written statement pursuant to paragraph (a)(2)(i) of this section is submitted during that time.

(3) An individual may request an accounting of disclosures for a period of time less than six years from the date of the request.

(b) Implementation specifications: Content of the accounting. The covered entity must provide the individual with a written accounting that meets the following requirements.

(1) Except as otherwise provided by paragraph (a) of this section, the accounting must include disclosures of protected health information that occurred during the six years (or such shorter time period at the request of the individual as provided in paragraph (a)(3) of this section) prior to the date of the request for an accounting, including disclosures to or by business associates of the covered entity.

(2) Except as otherwise provided by paragraphs (b)(3) or (b)(4) of this section, the accounting must include for each disclosure:

(i) The date of the disclosure;

(ii) The name of the entity or person who received the protected health information and, if known, the address of such entity or person;
(iii) A brief description of the protected health information disclosed; and

(iv) A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure or, in lieu of such statement, a copy of a written request for a disclosure under § 164.502(a)(2)(ii) or 164.512, if any.

(3) If, during the period covered by the accounting, the covered entity has made multiple disclosures of protected health information to the same person or entity for a single purpose under §§ 164.502(a)(2)(ii) or 164.512, the accounting may, with respect to such multiple disclosures, provide:

(i) The information required by paragraph (b)(2) of this section for the first disclosure during the accounting period;

(ii) The frequency, periodicity, or number of the disclosures made during the accounting period; and

(iii) The date of the last such disclosure during the accounting period.

(4)(i) If, during the period covered by the accounting, the covered entity has made disclosures of protected health information for a particular research purpose in accordance with § 164.512(i) for 50 or more individuals, the accounting may, with respect to such disclosures for which the protected health information about the individual may have been included, provide:

(A) The name of the protocol or other research activity;

(B) A description, in plain language, of the research protocol or other research activity, including the purpose of the research and the criteria for selecting particular records;

(C) A brief description of the type of protected health information that was disclosed;

(D) The date or period of time during which such disclosures occurred, or may have occurred, including the date of the last such disclosure during the accounting period;

(E) The name, address, and telephone number of the entity that sponsored the research and of the researcher to whom the information was disclosed; and

(F) A statement that the protected health information of the individual may or may not have been disclosed for a particular protocol or other research activity.

(ii) If the covered entity provides an accounting for research disclosures, in accordance with paragraph (b)(4) of this section, and if it is reasonably likely that the protected health information of the individual was disclosed for such research protocol or activity, the covered entity shall, at the request of the individual, assist in contacting the entity that sponsored the research and the researcher.

(c) Implementation specifications: Provision of the accounting.

(1) The covered entity must act on the individual's request for an accounting, no later than 60 days after receipt of such a request, as follows.

(i) The covered entity must provide the individual with the accounting requested; or

(ii) If the covered entity is unable to provide the accounting within the time required by paragraph (c)(1) of this section, the covered entity may extend the time to provide the accounting by no more than 30 days, provided that:

(A) The covered entity, within the time limit set by paragraph (c)(1) of this section, provides the individual with a written statement of the reasons for the delay and the date by which the covered entity will provide the accounting; and

(B) The covered entity may have only one such extension of time for action on a request for an accounting.

(2) The covered entity must provide the first accounting to an individual in any 12 month period without charge. The covered entity may impose a reasonable, cost-based fee for each subsequent request for an accounting by the same individual within the 12 month period, provided that the covered entity informs the individual in advance of the fee and provides the individual with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

(d) Implementation specification: Documentation. A covered entity must document the following and retain the documentation as required by § 164.530(j):
45 CFR § 164.528

(1) The information required to be included in an accounting under paragraph (b) of this section for disclosures of protected health information that are subject to an accounting under paragraph (a) of this section;

(2) The written accounting that is provided to the individual under this section; and

(3) The titles of the persons or offices responsible for receiving and processing requests for an accounting by individuals.

[67 FR 53271, Aug. 14, 2002]

<General Materials (GM) - References, Annotations, or Tables>

45 CFR § 164.528

END OF DOCUMENT
Supreme Court of Montana.

Kristin HENRICKSEN, individually and a parent and guardian of Hunter Henricksen, a minor, Plaintiff, Respondent and Cross-Appellant, v. STATE of Montana and Montana State University, Defendants and Appellants. - 319 Mont. 307, 84 P.3d 38, 2004 MT 20

No. 02-519.


Background: Mother, individually and as parent of child, brought negligence action against state and state university, arising out of incident in which child slipped between stairway balusters of second story open stairwell and fell approximately 20 feet, landing on his head and suffering three skull fractures. The District Court of the Eighteenth Judicial District, Gallatin County, Mike Salvagni, J., entered judgment upon jury verdict for mother and child, after reducing verdict amount by 20 percent based on mother's comparative negligence. State appealed. Mother cross-appealed.

Holdings: The Supreme Court, W. William Leaphart, J., held that:
(1) state had duty to maintain balcony and staircase at state university library in a safe condition for ordinary and public use;
(2) state breached this duty when it failed to take any remedial action following first child's fall;
(3) bifurcation of liability and damages was appropriate;
(4) bifurcation of mother's and son's damages was appropriate;
(5) state was prejudiced when it was denied right to discover mother's health care records;
(6) state was not prejudiced by exclusion of child's testimony by deposition or at trial;
(7) state was entitled to have mother submit to independent medical evaluation (IME);
(8) refusal to allow state's expert witness to testify as a discovery sanction was abuse of discretion; and
(9) evidence of another, prior fall that had occurred at same location as child's fall was admissible on issue of damages.

Affirmed in part, reversed in part, and remanded.


West Headnotes

[1] Colleges and Universities 5
81k5 Most Cited Cases
State had duty to maintain balcony and staircase at state university library in a safe condition for ordinary and public use, in negligence action brought by mother and child, arising out of incident in which child slipped between stairway balusters and fell approximately 20 feet, landing on his head and suffering three skull fractures; state knew distance between balusters of stairway was gaping 11 to 12 inches, which alone was sufficient to make child's fall foreseeable, state knew that approximately two weeks earlier, another child fell through balusters, and policy considerations supported imposition of duty upon state. MCA 27-1-701.

[2] Colleges and Universities 5
81k5 Most Cited Cases
State breached its duty to maintain balcony and staircase at state university library in a safe condition for ordinary and public use when it failed to take any remedial action following first child's fall, in negligence action brought by mother and child, arising out of incident in which child slipped between stairway balusters and fell approximately 20 feet, landing on his head and suffering three skull fractures; state had notice of defect caused by unsafe distance between stairway balusters when first fall occurred, but did not act to cure, remove, or warn of stairway defect. MCA 27-1-701.

228k181(33) Most Cited Cases
Although negligence actions involve questions of fact and are ordinarily not susceptible to summary judgment, when reasonable minds cannot differ, questions of fact can be determined as a matter of law. Rules Civ. Proc., Rule 56.

272k202 Most Cited Cases
A negligence action has four elements: (1) duty, (2) breach of duty, (3) causation, and (4) damages.

[5] Negligence 1692
272k1692 Most Cited Cases
Question of whether defendant owed a legal duty to
plaintiff and the scope of this duty are questions of law.

272k213 Most Cited Cases

Existence of a duty of care in a negligence action depends upon the foreseeability of the risk and upon a weighing of policy consideration for and against the imposition of liability.

272k215 Most Cited Cases

In a negligence action, the policy considerations weighed to determine whether to impose a duty include: (1) the moral blame attached to the defendant's conduct, (2) the desire to prevent future harm, (3) the extent of the burden to the defendant and the consequences to the community of imposing a duty to exercise care with resulting liability for breach, and (4) the availability, cost and prevalence of insurance for the involved.

[8] Negligence 1086
272k1086 Most Cited Cases

In a negligence action, a duty of care is breached, as a matter of law, if a defect or dangerous condition exists of a sufficient magnitude to cause a reasonable person to conclude that an accident is likely to occur because of the condition and the person or entity exercising control over the condition had notice of the defect.

[9] States 112.2(2)
360k112.2(2) Most Cited Cases

When the state has notice of a defect and opportunity to act, it has the duty to cure, remove, or warn of that defect.

[10] Highways 191
200k191 Most Cited Cases

The state has a duty to maintain sidewalks and highways in a safe condition for ordinary and public use.

[11] States 112.2(2)
360k112.2(2) Most Cited Cases
When defects are present, the state's duty to cure or remove the same, or give warning thereof, begins when it has notice of the same and opportunity to act.

[12] Negligence 213
272k213 Most Cited Cases
In a negligence action, foreseeability is determined at the time the event occurred, irrespective of a long history free from accidents.

[13] Negligence 1032
272k1032 Most Cited Cases

Property owners owe a duty of ordinary care to keep the premises reasonably safe and to warn people of any hidden or lurking dangers; this duty is not abrogated by either a long or relatively accident-free history, or having a building grandfathered in under older building codes.

[14] Trial 3(5.1)
388k3(5.1) Most Cited Cases
Bifurcation of liability and damages was appropriate, in negligence action brought by mother and child, arising out of incident in which child slipped between stairway balusters at state university library and fell, suffering three skull fractures; duplication of evidence would have been minimal, because evidence proving liability and that proving damages was fundamentally different, and witnesses for liability phase could have been lost or their memories clouded if they had to wait to testify until full extent of child's damages was known. Rules Civ.Proc., Rule 42(b).

[15] Trial 3(4)
388k3(4) Most Cited Cases
Bifurcation of mother's and son's damages was appropriate, in negligence action brought by mother and child, arising out of incident in which child slipped between stairway balusters at state university library and fell, suffering three skull fractures; because of child's young age, full extent of his damages would not be known for several years, forcing mother to wait until time when child's damages were fully assessable or forcing both issues to be tried before child's damages were fully known.
would have been prejudicial, and, although same facts surrounded underlying accident causing both mother's and child's damages, claims were fundamentally different.  

[16] Trial  
388k3(1) Most Cited Cases  
A court may bifurcate claims in order to avoid the danger of prejudice or for court convenience.  


[17] Trial  
388k3(2) Most Cited Cases  
The decision whether to bifurcate claims is a matter left to the broad discretion of the district court.  


[18] Appeal and Error  
949  
30k949 Most Cited Cases  
Supreme Court reviews a decision to bifurcate claims for abuse of discretion.  


[19] Appeal and Error  
946  
30k946 Most Cited Cases  
Test for abuse of discretion is whether the trial court acted arbitrarily without employment of conscientious judgment or exceeded the bounds of reason resulting in substantial injustice.  

[20] Trial  
388k3(1) Most Cited Cases  
It is not appropriate to bifurcate issues when the issues are so intertwined that if they are separated it will create confusion and uncertainty, or needless and endless litigation.  


[21] Witnesses  
219(5)  
410k219(5) Most Cited Cases  
Mother waived her statutory right to confidentiality with respect to her medical records, but only to extent that it was necessary for state to discover whether mother's current medical or physical condition was result of some other cause, in negligence action brought by mother and child, arising out of incident in which child slipped between stairway balusters at state university library and fell, suffering three skull fractures; mother's claims involved emotional distress, loss of consortium, and post-traumatic stress disorder (PTSD), and similarity between mother's present claims and those for which she was previously treated showed possible correlation between her pre-accident records and her present claims.  

Const. Art. 2, § 10;  

[22] Appeal and Error  
1043(6)  
30k1043(6) Most Cited Cases  

[23] Pretrial Procedure  
19  
307Ak19 Most Cited Cases  
The trial court has inherent discretionary power to control discovery based on its authority to control trial administration.  

[24] Appeal and Error  
961  
30k961 Most Cited Cases  
Supreme Court reviews a district court's rulings on discovery motions for an abuse of discretion.  

[25] Appeal and Error  
1043(6)  
30k1043(6) Most Cited Cases  
Party claiming error in the district court's discovery rulings must show prejudice.  

[26] Appeal and Error  
961  
30k961 Most Cited Cases  
Supreme Court will reverse trial court's discretionary rulings pertaining to discovery only when the court's judgment may materially affect the substantial rights of the complaining party and allow the possibility of a miscarriage of justice.  

[27] Constitutional Law  
82(7)  
92k82(7) Most Cited Cases  
Medical records are private and deserve the utmost constitutional protection.  

Const. Art. 2, § 10.  

[28] Witnesses  
219(5)  
410k219(5) Most Cited Cases  
When a party claims damages for physical or mental injury, he places the extent of that physical or mental injury at issue and waives his statutory right to confidentiality to the extent that it is necessary for a defendant to discover whether plaintiff's current medical or physical condition is the result of some
other cause.

[29] Witnesses 219(4.1)
410k219(4.1) Most Cited Cases
A plaintiff's waiver of his statutory right to confidentiality with respect to medical records is not unlimited; defendant may only discover records related to prior physical or mental conditions if they relate to currently claimed damages, and the plaintiff's right to confidentiality is balanced against the defendant's right to defend itself in an informed manner.

[30] Constitutional Law 82(7)
92k82(7) Most Cited Cases
Under constitutional guarantee of informational privacy in the security of one's medical records, a defendant is not entitled to unnecessarily invade privacy of a plaintiff claiming damages for physical or mental injury, by exploring totally unrelated or irrelevant matters. Const. Art. 2, § 10.

[31] Pretrial Procedure 411
307Ak411 Most Cited Cases
An in camera review is often used at various stages throughout discovery and trial to balance the privacy interests of the parties and the need to know; this review can effectively offer protection to both parties by avoiding needless exposure of potentially harmful information.

[32] Pretrial Procedure 411
307Ak411 Most Cited Cases
The in camera review allows the trial court to preview potentially damaging information before it is released and decide what information is properly discoverable.

[33] Pretrial Procedure 371
307Ak371 Most Cited Cases

[33] Pretrial Procedure 372
307Ak372 Most Cited Cases

[33] Pretrial Procedure 378
307Ak378 Most Cited Cases
State was not entitled to discover mother's financial documents, school transcript, or personnel records, in negligence action brought by mother and child, arising out of incident in which child slipped between stairway balusters at state university library and fell, suffering three skull fractures; mother did not claim lost earnings or lost earning capacity, rather, her mental and emotional states were at issue, and requested documents had no bearing on these issues.

[34] Appeal and Error 1043(6)
30k1043(6) Most Cited Cases

[34] Appeal and Error 1057(1)
30k1057(1) Most Cited Cases
State was not prejudiced by exclusion of child's testimony by deposition or at trial, in negligence action brought by mother and child, arising out of incident in which child slipped between stairway balusters at state university library and fell, suffering three skull fractures; due to his young age, child did not remember accident or his mother's condition before accident, and thus child could not testify as to how accident changed mother's life, state had opportunity to question mother and other adult witnesses regarding her condition before and after child's accident, and state had opportunity to use expert testimony regarding child's condition.

[35] Appeal and Error 964
30k964 Most Cited Cases
Supreme Court reviews a grant or denial of a motion in limine for an abuse of discretion.

[36] Appeal and Error 961
30k961 Most Cited Cases
Supreme Court will not overturn a district court's ruling on discovery unless the party alleging error proves an abuse of discretion and resulting prejudice.

[37] Witnesses 40(1)
410k40(1) Most Cited Cases
There is no minimum age requirement with regard to child testimony.

[38] Witnesses 228
410k228 Most Cited Cases
Child witnesses need protection against the potential emotional and psychological injuries that may occur with regular litigation procedures.

[39] Damages 206(4)
115k206(4) Most Cited Cases
State was entitled to have mother submit to independent medical evaluation (IME), in negligence action brought by mother and child, arising out of incident in which child slipped between stairway balusters at state university library and fell, suffering three skull fractures; state did not know that mother planned to use her past diagnosis of post traumatic stress syndrome (PTSD) as basis for damages in current action, and when state did become aware of
this fact, it timely filed its motions to have mother undergo an IME, and, in filing motions, it complied with trial court's discovery deadlines. Rules Civ.Proc., Rule 35.

[40] Damages 206(8) 115k

Trial court's refusal to allow state's expert witness to testify as a discovery sanction against state was abuse of discretion, in negligence action brought by mother and child, arising out of incident in which child slipped between stairway balusters at state university library and fell, suffering three skull fractures; sanction was too severe, given that discovery abuse committed by state, if any, was tardy request for independent medical evaluation (IME) of mother, which was still within court-mandated time, and if expert's testimony was not comprehensively described in discovery responses, that was in large part due to trial court's rulings precluding the IME and excluding full access to mother's medical records. Rules Civ.Proc., Rule 26.

[41] Damages 206(2) 115k

A plaintiff in a negligence action who asserts mental or physical injury places that mental or physical injury clearly in controversy and provides the defendant with good cause for an examination to determine the existence and extent of such asserted injury; thus if a plaintiff alleges mental or physical injury, he puts the existence of that injury at issue and provides the defendant with good cause to request that an independent medical evaluation (IME) be conducted. Rules Civ.Proc., Rule 35.

[42] Pretrial Procedure 307Ak 15

The underlying policies of rule governing discovery are to eliminate surprise and to promote effective cross-examination of expert witnesses. Rules Civ.Proc., Rule 26.

[43] Pretrial Procedure 307Ak 44.1

Criteria to determine whether a discovery sanction is an abuse of discretion or too severe are: (1) whether the consequences imposed by the sanctions relate to the extent and nature of the actual discovery abuse, (2) the extent of the prejudice to the opposing party which resulted from the discovery abuse, and (3) whether the court expressly warned the abusing party of the consequences. Rules Civ.Proc., Rule 26.

[44] Damages 192 115k

Evidence of mother's unrelated stressors and prior counseling was inadmissible, in negligence action brought by mother and child, arising out of incident in which child slipped between stairway balusters at state university library and fell, suffering three skull fractures; state failed to present expert testimony that established a causal connection between mother's present symptoms and other stressors or prior counseling, and, absent the causal link, state was not entitled to present alternate causation evidence.

[45] Pretrial Procedure 307Ak 3

Trial court has the inherent power to deny or grant a motion in limine to ensure that a fair trial is afforded to all parties.

[46] Damages 166(1) 115k

Litigants must establish a causal connection more probable than not connecting any possible cause of a plaintiff's injuries before alternate causation testimony is allowed at trial in a negligence action; mere speculation is not sufficient and not admissible.

[47] Appeal and Error 970(2) 30k

Trial court has broad discretion to determine whether evidence is relevant and admissible, and Supreme Court will not overturn the district court's decision absent an abuse of discretion.

[48] Evidence 141 157k

Evidence of another, prior fall that had occurred at same location as child's fall was admissible on issue of damages, in negligence action brought by mother and child, arising out of incident in which child slipped between stairway balusters at state university library and fell, suffering three skull fractures;
mother's learning of prior fall made her claim of psychological/emotional distress more or less probable, and, as such, it was relevant to issue of damages. Rules of Evid., Rule 401.

[49] Damages ¶ 57.14
115k57.14 Most Cited Cases
(Formerly 115k49.10)
Cause of action for negligent infliction of emotional distress will arise under circumstances where serious or severe emotional distress to plaintiff was reasonably foreseeable consequence of defendant's negligent act or omission.

[50] Damages ¶ 57.27
115k57.27 Most Cited Cases
(Formerly 115k51)
One is not required to be a bystander at accident to have a valid claim for damages due to negligence infliction of emotional distress; it is one factor a court can consider, but it is not determinative.

[51] Damages ¶ 192
115k192 Most Cited Cases
Severe and serious standard for proving emotional distress on a claim for negligent infliction of emotional distress applied in negligence action brought by mother and child, arising out of incident in which child slipped between stairway balusters at state university library and fell, suffering three skull fractures, and this standard could be met by proof that emotional distress resulted in shock, illness, or other bodily harm.

[52] Trial ¶ 182
388k182 Most Cited Cases
Trial court has broad discretion in determining whether to give a proposed jury instruction.

[53] Appeal and Error ¶ 969
30k969 Most Cited Cases
Supreme Court will not reverse a district court on the basis of its jury instructions absent an abuse of discretion.

[54] Trial ¶ 295(1)
388k295(1) Most Cited Cases
In reviewing whether a particular jury instruction was properly given or refused, Supreme Court considers the instruction in its entirety, as well as in connection with the other instructions given and with the evidence introduced at trial.

[55] Appeal and Error ¶ 1032(3)
In cases where there is a physical manifestation of bodily harm resulting from emotional distress, such as post traumatic-stress disorder (PTSD), this bodily harm is sufficient evidence that the emotional distress suffered by the plaintiff is genuine and severe.

Loss of established course of life and emotional distress are two separate and distinct claims with differing elements and different compensable damages; hence, if supported by the evidence, a separate recovery is allowed for each, and whether the damages overlap is a question of proof.

Videotape of child, proffered by state as demonstrative evidence showing him as a well-adjusted child, not suffering from any deficits, was inadmissible, in negligence action brought by mother and child, arising out of incident in which child slipped between stairway balusters at university library and fell, suffering three skull fractures; videotape did not supplement testimony or clarify issues, and it was not accurate depiction of child's life.

Trial court has broad discretion in admitting or excluding evidence.

Decision whether to admit videotape evidence lies in the discretion of the trial court and will not be reversed absent a manifest abuse of discretion.

For an exhibit to be admissible for demonstrative purposes, it must supplement a witness's spoken description of the transpired event, clarify some case issue, and be more probative than prejudicial.

For Respondent: Monte D. Beck, Beck, Richardson & Amsden, PLLC, Bozeman, Montana.

Justice W. WILLIAM LEAPHART delivered the Opinion of the Court.

The issues on appeal are as follows:

1. Whether the District Court erred in granting partial summary judgment on the issue of liability?
2. Whether the District Court erred in bifurcating liability and damages and in bifurcating Kristin's and Hunter's damages?
3. Whether the District Court erred in denying the production of (1) Kristin's medical and mental health records; and (2) her financial documents, school transcripts, and personnel records?
4. Whether the District Court erred in not allowing the State to depose Hunter or to call him as a witness?
5. Whether the District Court erred in prohibiting the State from conducting an IME and

It was not abuse of discretion to refuse to grant state's request to dismiss jurors for cause, on basis that jurors were biased because, days before trial, they saw local newspaper article that mentioned prior fall in state university library, in negligence action brought by mother and child, arising out of incident in which child slipped between stairway balusters at university library and fell, suffering three skull fractures; juror who stated that he was not sure if he could keep prior fall out of his mind was excused, and other jurors stated they would be able to keep an open mind and fairly decide case. MCA 25-7-223(7).
in excluding the State's expert witness?
¶ 8 6. Whether the District Court erred in excluding evidence of (1) stressors in Kristin's life unrelated to the accident and counseling services Kristin received prior to Hunter's accident; and (2) a prior fall at the MSU library?
¶ 9 7. Whether the District Court erred in its jury instructions for the claims of emotional distress and loss of established course of life?
¶ 10 8. Whether the District Court erred in excluding the videotapes of Hunter?
¶ 11 9. Whether the District Court erred in not dismissing jurors for cause?

Factual and Procedural Background
¶ 12 On November 2, 1995, Kristin and her three-year-old son Hunter were at the Montana State University (MSU) library. Hunter slipped between the stairway balusters of a second story open stairwell and fell approximately twenty feet to the concrete floor below, landing on the left side of his head. Within hours of Hunter's fall, Kristin learned that another child had fallen through the same stairway weeks earlier. As a result of this fall, Hunter suffered three skull fractures. Since the fall, medical tests have revealed that an area of his brain tissue about the size of a golf ball has atrophied.

¶ 13 On December 17, 1996, Kristin individually, and as parent of Hunter, filed a complaint against the State. Kristin's claim was based on emotional distress, loss of consortium, and post-traumatic stress disorder, all related to Hunter's fall. Hunter's claim was for medical expenses related to his injuries, loss of enjoyment of lifestyle, and pain and suffering.

¶ 14 On February 23, 1999, the District Court granted partial summary judgment against the State, regarding duty and breach. The court bifurcated the issues of liability and damages and also the issues of Kristin's and Hunter's damages.

¶ 15 The court granted motions in limine excluding the following evidence: lack of prior accidents at the library; evidence that the stairway complied with the Uniform Building Code in effect at the time the stairway was constructed; evidence of a child's fall weeks before Hunter's fall from the same stairway; and evidence concerning Kristin's divorce and prior unrelated counseling. The court also granted a motion to strike Dr. David Price's testimony and limit Dr. Paul Bach's testimony (both expert witnesses for the State). After conducting an in camera review of Kristin's medical records, the court denied a motion to compel production of Kristin's health care records from before and after Hunter's fall. The court also denied the motion to compel production of all Kristin's financial documents. The State requested, before the discovery deadline, an independent medical examination of Kristin which the District Court at first granted but later denied after reconsideration.

¶ 16 At the start of the trial, beginning on April 15, 2002, the State challenged several jurors for cause because they had read a newspaper article regarding Hunter's accident that mentioned the prior fall. All but one of these challenges were denied after the jurors were questioned about potential bias. After a five-day trial, a jury rendered a verdict against the State. The verdict amount was reduced by 20 percent based on Kristin's comparative negligence.

¶ 17 The State has appealed numerous issues, delineated above. In the event that a new trial is ordered, Kristin cross-appealed the preclusion of the evidence regarding the prior fall. We affirm in part and reverse in part.

Discussion
¶ 18 Issue 1: Whether the District Court erred in granting partial summary judgment on the issue of liability?

[1][2][3] ¶ 19 We review a district court's grant of summary judgment de novo, applying the same criteria as the district court, based on Rule 56, M.R.Civ.P. Wiley v. City of Glendive (1995), 272 Mont. 213, 216, 900 P.2d 310, 312. The party moving for summary judgment must demonstrate that no genuine issues of material fact exist. Wiley, 272 Mont. at 216, 900 P.2d at 312. If this is demonstrated, "the burden then shifts to the party opposing the motion to establish otherwise." Wiley, 272 Mont. at 216, 900 P.2d at 312. Although negligence actions involve questions of fact and are ordinarily not susceptible to summary judgment, when reasonable minds cannot differ, questions of fact can be determined as a matter of law. Wiley, 272 Mont. at 216, 900 P.2d at 312.

[4] ¶ 20 A negligence action has four elements: (1) duty; (2) breach of duty; (3) causation; and (4) damages. Wiley, 272 Mont. at 217, 900 P.2d at 312. In this case, the District Court granted summary judgment on the duty and breach of duty elements. Causation and damages were left for determination at trial.

[5][6][7] ¶ 21 The question of whether the
State owed a legal duty to Kristin and Hunter and the scope of this duty are questions of law. Webb v. T.D. (1997), 287 Mont. 68, 951 P.2d 1008, 1011. "The existence of a duty of care depends upon the foreseeability of the risk and upon a weighing of policy consideration for and against the imposition **46 of liability." Estate of Strever v. Cline (1996), 278 Mont. 165, 173, 924 P.2d 666, 670. The policy considerations weighed to determine whether to impose a duty include:

(1) the moral blame attached to the defendant's conduct; (2) the desire to prevent future harm; (3) the extent of the burden to the defendant and the consequences to the community of imposing a duty to exercise care with resulting liability for breach; and (4) the availability, cost and prevalence of insurance for the involved.

Estate of Strever, 278 Mont. at 173, 924 P.2d at 670.

¶ 22 A duty of care is breached, as a matter of law, if a defect or dangerous condition exists of a sufficient magnitude to cause a reasonable person to conclude that an accident is likely to occur because of the condition and the person or entity exercising control over the condition had notice of the defect. Wiley, 272 Mont. at 218, 900 P.2d at 313. "When the State has notice of a defect and opportunity to act, it has the duty to cure, remove, or warn of that defect." Wiley, 272 Mont. at 217, 900 P.2d at 313.

¶ 23 After reviewing the record before us, we conclude that the State owed a duty of ordinary care to prevent children from falling through the balusters in the MSU library. Section 27-1-701, MCA. As the State has a duty to maintain sidewalks and highways in a safe condition for ordinary and public use, Wiley, 272 Mont. at 217, 900 P.2d at 312, so too does it have a duty to maintain the balcony and staircase at the MSU library in a safe condition for ordinary and public use. The State knew the distance between the balusters of the stairway was a gaping eleven to twelve inches. This alone was sufficient to make Hunter's fall foreseeable. Additionally, the State knew that approximately two weeks earlier another child fell through the balusters at the library. After this first accident, the dangerous condition of the balusters could not be ignored. Yet the State did not act.

¶ 24 Policy considerations support the imposition of a duty upon the State. The baluster spacing which led to the accident was in a state library open to the public. Society has a legitimate interest in prevention of harm to all library users because the library should be safe for all users and their children. The State had a minimal burden *315 placed upon it to remedy the situation, as shown by the placement of chickenwire in front of the balusters within twenty-four hours of Hunter's fall. Lastly, the public suffers no negative cost if the State is held to a duty of care because any liability is covered by the State's insurance.

¶ 25 The State breached its duty of ordinary care when it failed to take any remedial action following the first fall. The State had a duty to maintain the stairway in a reasonably safe condition and to take measures to prevent small children from falling through the balusters. The State had notice of the defect caused by the unsafe distance between the stairway balusters when the first fall occurred. "When defects are present the State's duty to cure or remove the same, or give warning thereof begins when it has notice of the same and opportunity to act." Buck v. State (1986), 222 Mont. 423, 430, 723 P.2d 210, 214 (overruled on other grounds). Here, despite notice, the State did not act to cure, remove, or warn of the stairway defect.

¶ 26 The State contends that because it had a relatively accident-free history at the library and the building was grand-fathered in under an older version of the Uniform Building Code there are genuine issues of material fact which make summary judgment inappropriate. However, foreseeability is determined at the time the event occurred, irrespective of a long history free from accidents. Jackson v. State, 1998 MT 46, ¶¶ 56-58, 287 Mont. 473, ¶¶ 56-58, 956 P.2d 35, ¶¶ 56-58.

¶ 27 "Property owners owe a duty of ordinary care to keep the premises reasonably safe and to warn people of any hidden or lurking dangers." Welton v. Lucas (1997), 283 Mont. 202, 207, 940 P.2d 112, 115. This duty is not abrogated by either a long or relatively accident-free history, Allis-Chalmers Corp. v. Occupational Safety & Health Review Com. (7th Cir.1976), 542 F.2d 27, 31 (an employer's accident-free record may be **47 considered in determining the gravity of a safety violation but the record is not dispositive); Faultless Div., Bliss & Laughlin Indus., Inc. v. Secretary of Labor (7th Cir.1982), 674 F.2d 1177, 1184 (a history free from accidents is not dispositive regarding whether a safety regulation violation occurred), or having a building grand-fathered in under older building codes, Moffatt v. University of Montana (1992), 254 Mont. 285, 837 P.2d 401 (compliance of stairs with building code does not prove conclusively that property owner properly maintained its premises); Hull v. Greater Cleveland Reg'l Transit Auth. (Ohio App.1987), 1987
Bifurcation of liability from damages is appropriate because witnesses (for the liability phase) could be lost or their memories clouded if they have to wait to testify until the full extent of Hunter's damages is known. The trial court also stated that a finding of liability may help speed the judicial process by enhancing the possibility of a settlement.

¶ 32 Bifurcation of Kristin's and Hunter's damages is appropriate because Kristin's damages are currently assessable. Because of Hunter's young age, the full extent of his damages will not be known for several years. Forcing Kristin to wait until the time when Hunter's damages are fully assessable or forcing both issues to be tried now, before Hunter's damages are fully known, would be prejudicial. Although the same facts surround the underlying accident causing both Kristin's and Hunter's damages, the claims are fundamentally different. Although slight overlap of witnesses may occur between their claims, the witnesses and evidence will not be extensively duplicated. Different witnesses will and have provided testimony regarding the impact the accident had on Kristin and on Hunter.

¶ 33 Based on the foregoing, we conclude that the District Court did not abuse its discretion by ordering bifurcation. Unlike **48 the Fitzgerald decision, judicial economy in this case does not call for a unified trial. The District Court did not act arbitrarily without employment of conscientious judgment or exceed the bounds of reason. Bifurcation was appropriate both for court convenience and to prevent prejudice resulting in substantial injustice. We affirm.

¶ 34 Issue 3: Whether the District Court erred in denying the production of (1) Kristin's medical and mental health records; and (2) her financial documents, school transcripts, and personnel records?

Medical and Mental Health Records

¶ 35 "The District Court has inherent discretionary power to control discovery based on its authority to control trial administration." Anderson v. Werner Enterprises, Inc., 1998 MT 333, ¶ 13, 292 Mont. 284, ¶ 13, 972 P.2d 806, ¶ 13. We review a district court's rulings on discovery motions for an abuse of discretion. Anderson, ¶ 13. The party claiming error in the district court's discovery rulings must show prejudice. Anderson, ¶ 13. We will reverse these discretionary rulings only when the court's "judgment may materially affect the substantial rights of the complaining party and allow the possibility of a miscarriage of justice." Anderson, ¶ 13.
[27][28][29][30] ¶ 36 Medical records are private and "deserve the utmost constitutional protection." State v. Nelson (1997), 283 Mont. 231, 242, 941 P.2d 441, 448. Article II, Section 10, of the Montana Constitution guarantees informational privacy in the sanctity of one's medical records. Nelson, 283 Mont. at 242, 941 P.2d at 448. However, "[w]hen a party claims damages for physical or mental injury, he or she places the extent of that physical or mental injury at issue and waives his or *318 her statutory right to confidentiality to the extent that it is necessary for a defendant to discover whether plaintiff's current medical or physical condition is the result of some other cause." State ex rel. Mapes v. District Court (1991), 250 Mont. 524, 530, 822 P.2d 91, 94. Nonetheless, the waiver is not unlimited; the defendant may only discover records related to prior physical or mental conditions if they relate to currently claimed damages. The plaintiff's right to confidentiality is balanced against the defendant's right to defend itself in an informed manner. State ex rel. Mapes, 250 Mont. at 530, 822 P.2d at 94. A defendant "is not entitled to unnecessarily invade plaintiff's privacy by exploring totally unrelated or irrelevant matters." State ex rel. Mapes, 250 Mont. at 530, 822 P.2d at 95.

[31][32] ¶ 37 The District Court denied the State's motion to compel production of all Kristin's health care records (including medical and counseling records) from before and after Hunter's fall and granted a protective order on the basis that the records were constitutionally protected, irrelevant to the issues in this case, and therefore not discoverable. The court conducted an in camera review of Kristin's medical records. An in camera review is often used at various stages throughout discovery and trial "to balance the privacy interests of the parties and the need to know. The in camera procedure can effectively offer protection to both parties by avoiding needless exposure of potentially harmful information." State v. Burns (1992), 253 Mont. 37, 39, 830 P.2d 1318, 1319-20. The court can preview potentially damaging information before it is released, Burns, 253 Mont. at 39, 830 P.2d at 1320, and decide what information is properly discoverable, In re Lacy (1989), 239 Mont. 321, 326, 780 P.2d 186, 189.

¶ 38 A defendant is not allowed unfettered access to all medical records he believes may help his defense. In State v. Mix, the trial court refused access to records because the subject matter was irrelevant and too remote to the case. State v. Mix (1989), 239 Mont. 351, 360, 781 P.2d 751, 756. In that case, a defendant charged with deliberate homicide sought medical records regarding the victim's asthma condition. Mix, 239 Mont. at 360, 781 P.2d at 756.

¶ 39 In the present case, Kristin commenced an action for damages for her personal injuries which placed in issue her mental and physical condition arising from the accident. Jaap v. District Court (1981), 191 Mont. 319, 322, 623 P.2d 1389, 1391; State ex rel. Mapes, 250 Mont. at 530, 822 P.2d at 94. *49 In doing this, she waived any physician-patient privilege as to a mental or physical condition in controversy. Jaap, 191 Mont. at 322, 623 P.2d at 1391; Rule 35(b)(2), M.R.Civ.P. This includes *319 testimony her physicians may have provided concerning her prior mental condition. Kristin did not produce records from before Hunter's accident because the records were "sensitive and personal." She did produce redacted medical records for the period after Hunter's accident which she determined were relevant. The State did view the redacted portion of Kristin's medical records. However, the State sought all Kristin's mental and medical health records from ten years before Hunter's accident (1985) through time of trial.

¶ 40 Kristin claims that because she provided her doctors with complete copies of the disputed medical records, and her doctors stated the records showed no causal correlation between any previous injury or condition and her current injuries, this ends the inquiry into the medical records. Kristin argues that the State should be denied access to the records because it did not present any expert medical opinion that her alleged injuries were more probably than not caused by some factor other than witnessing Hunter's fall. The fallacy in this argument is that there was no expert medical opinion before Judge Jaap's time. State v. Burns (1992), 253 Mont. 37, 39, 830 P.2d 1318, 1319-20. This includes *319 testimony her physicians may have provided concerning her prior mental condition. Kristin did not produce records from before Hunter's accident (1985) through time of trial.

¶ 41 The State was prejudiced when it was denied the right to defend itself in an informed manner. It had the right to discover evidence related to prior physical or mental conditions possibly connected to Kristin's current damages. State ex rel. Mapes, 250 Mont. at 530, 822 P.2d at 94. The State is not entitled to unnecessarily invade Kristin's privacy by exploring totally unrelated or irrelevant matters. State ex rel. Mapes, 250 Mont. at 530, 822 P.2d at 95. However, because Kristin presented her entire
medical records file to her treating physicians and asked for their expert medical opinions, which were at least in part based on the records which were denied to the defense, she waived her statutory right to confidentiality but only to the extent that it is necessary for the State to discover for itself whether Kristin's current medical or physical condition is the result of some other cause. State ex rel. Mapes, 250 Mont. at 530, 822 P.2d at 94. The State thus has a right to review Kristin's medical records to determine whether her present condition is attributable to some preexisting cause.

¶ 42 The similarity between Kristin's present claims and those for which she was previously treated shows the possible correlation between her pre-accident records and her present claims. Kristin's *320 claims involve emotional distress, loss of consortium, and post-traumatic stress disorder (PTSD). The record indicates that prior to Hunter's accident, she was taking medications which can be used to treat depression, headaches, sleep disorders, and anxiety. The connection between Kristin's present claims and her past conditions is not attenuated as it was in Mix where access to records was denied. Mix, 239 Mont. at 360, 781 P.2d at 756. Accordingly, we reverse the District Court's denial of the State's motion to compel production of the medical records.

Financial Documents, School Transcripts, and Personnel Records

¶ 43 The District Court granted an order protecting Kristin's financial documents, school transcript, and personnel records. The State sought to have these records produced in an effort to quantify Kristin's damages. However, the court ruled that Kristin's statement of damages was sufficient and the documents were not likely to lead to discovery of any relevant information.

¶ 44 Because the State is the party alleging error in the District Court's discovery rulings, the State must show how it was prejudiced by the trial court's ruling. Anderson, ¶ 13. Kristin does not claim lost earnings or lost earning capacity; rather her mental and emotional states are at issue. The requested documents have no bearing on these legitimate issues. The State fails to show that the denial of the requested documents *50 substantially prejudiced it or impaired its ability to present a defense. We find no abuse of discretion. We affirm.

¶ 45 Issue 4: Whether the District Court erred in not allowing the State to depose Hunter or to call him as a witness?

¶ 46 We review a grant or denial of a motion in limine for an abuse of discretion. Bramble v. State, 1999 MT 132, ¶ 16, 294 Mont. 501, ¶ 16, 982 P.2d 464, ¶ 16. We will not overturn a district court's ruling on discovery unless the party alleging error proves an abuse of discretion and resulting prejudice. Anderson, ¶ 13. Rule 26(c), M.R.Civ.P., allows a court to "make any order which justice requires to protect a party or person from annoyance, embarrassment, oppression, or undue burden ... including ... that the discovery not be had[,]" There is no minimum age requirement with regard to child testimony. State v. Eiler (1988), 234 Mont. 38, 42, 762 P.2d 210, 213 (testimony from four-year-old and five-year-old children allowed). However, child witnesses need "protection against the potential emotional and psychological injuries" that may occur with regular litigation procedures. State v. Sor-Lokken (1991), 247 Mont. 343, 349, 805 P.2d 1367, 1372. Furthermore, *321 needless cumulative evidence may be excluded. Rule 403, M.R.Evid.

¶ 47 The District Court issued a protective order precluding a deposition of Hunter and reaffirmed this decision when it granted a motion in limine to exclude Hunter as a witness. The court reasoned that because Hunter was only three years old at the time of the accident, and only nine years old at the time of the trial, little probative information could be gained by forcing him to testify regarding the stress his mother suffers because of his head injury. The court also stated that such testimony would be traumatic and unduly burdensome to Hunter. Additionally, any information Hunter could have provided was available from other witnesses, such as physicians and school teachers, and thus would be cumulative. Rule 403, M.R.Evid.

¶ 48 The State has failed to show prejudice resulting from the exclusion of Hunter's testimony. Due to his young age, Hunter does not remember the accident or his mother's condition before the accident. He could not testify as to how the accident changed her life. The State had the opportunity to question Kristin and other adult witnesses regarding her condition before and after Hunter's accident.

¶ 49 Furthermore, because the State had the opportunity to use expert witness testimony regarding Hunter's condition, it did not need Hunter to testify regarding the effects the accident had on him. The State listed Dr. Bach as an expert witness for Kristin's...
trial to present testimony based on his examination of Hunter and also to report on Hunter's past and present condition. Since the State could have used Dr. Bach's testimony but chose not to, it was not prejudiced by the inability to call Hunter as a witness. The court did not act arbitrarily without conscientious judgment and did not abuse its discretion. We affirm the order of the court protecting Hunter from having to testify at deposition or at trial.

¶ 50 Issue 5: Whether the District Court erred in prohibiting the State from conducting an IME and in excluding the State's expert witness?

¶ 51 We review a district court's rulings on discovery motions for an abuse of discretion. Anderson, ¶ 13. Rule 35, M.R.Civ.P., recognizes an independent medical examination (IME) as a form of discovery. This Court has recognized an IME as a valid tool to determine if and to what extent a defendant suffers from an alleged injury. Winslow v. Montana Rail Link, 2001 MT 269, ¶ 16, 307 Mont. 269, ¶ 16, 38 P.3d 148, ¶ 16. "A plaintiff in a negligence action who asserts mental or physical injury places that mental or physical injury clearly in controversy and provides the defendant with good cause to request that an IME be conducted. Winslow, ¶ 9."

¶ 52 In this case, the court issued a scheduling order that required exchange of all expert witnesses (including a comprehensive statement of the proposed expert's opinions and the grounds for the opinions) by November 15, 2001. The discovery deadline was December 15, 2001. The court amended the deadline for taking depositions to January 25, 2002.

¶ 53 As early as September 23, 1997, and numerous times thereafter, the State had access to records that indicated Kristin suffered from emotional distress resulting from her son's injuries. However, it was not until October 22, 2001, that Kristin used, for the first time, the term "on-going post traumatic stress" in a supplemental discovery response. Kristin's November 15, 2001, expert witness disclosure stated that Dr. Erin Bigler believed Kristin suffered from PTSD. On this same day, the State disclosed Dr. Price as an expert witness, and reserved the right to conduct an IME of Kristin. The State disclosed Dr. Price's general opinion without details because he had not yet performed the IME. On November 30, 2001, the State requested Kristin submit to an IME. Kristin did not make herself available for this examination.

¶ 54 On December 6, 2001, the State moved the court to order Kristin to submit to an "emergency IME" because it had not been previously informed Kristin suffered from PTSD. This motion, made before the discovery deadline, was initially granted. However, the IME was later denied because, after reconsideration, the court determined that since the State knew of Kristin's PTSD since September 1997, the request for the IME came too late in the proceedings. We are not so persuaded.

¶ 55 Kristin claims the State had four years to conduct an IME because she provided the State with her mental health records from 1997 which contained the PTSD diagnosis. Nonetheless, the mere existence of the record is insufficient notice that she was planning to use this diagnosis as a basis for damages in the present lawsuit. The State did not know that fact until the supplemental discovery response from October of 2001. Upon learning this, the State timely filed its motions to have Kristin undergo an IME so that the State could adequately prepare its defense. If Kristin had earlier revealed the fact that she was going to use the PTSD diagnosis as a basis for damages, the State would not have been forced to run so close to the ever-lingooming discovery deadline. As it was, the State complied with the court's discovery deadlines. We reverse the court's denial of the State's request for an IME.

¶ 56 Now we examine the fact that Dr. Price was precluded from testifying as a witness. The State disclosed Dr. Price as an expert witness within the time-limit imposed by the scheduling order. The State twice provided the required supplementation regarding his testimony, to the extent possible given the limited amount of information with which he had to work. The court, however, barred Dr. Price from testifying as a witness because he had not conducted an IME as a basis for his testimony. Although much of the information necessary to provide a comprehensive report was not available to him because Kristin's complete medical records and the IME were denied, Dr. Price still could have testified based on his medical knowledge and the redacted medical records available to him.

¶ 57 "The underlying policies of Rule 26, M.R.Civ.P., are to eliminate surprise and to promote effective cross-examination of expert witnesses."
In this case, the District Court sanctioned the State by preventing Dr. Price from testifying. We have identified the following criteria to determine whether a sanction is an abuse of discretion or too severe: "1) whether the consequences imposed by the sanctions relate to the extent and nature of the actual discovery abuse; 2) the extent of the prejudice to the opposing party which resulted from the discovery abuse; and 3) whether the court expressly warned the abusing party of the consequences." Maloney v. Home & Investment Center, Inc., 2000 MT 34, ¶ 35, 298 Mont. 213, ¶ 35, 994 P.2d 1124, ¶ 35.

Applying the above criteria, we determine that the court sanction was too severe. The discovery abuse committed by the State, if any, was a tardy request for an IME which was, nonetheless, still within the court-mandated time. An IME need not be conducted by the date set for expert disclosures. The State provided a list of expert witnesses, including Dr. Price, by the court-imposed deadline. The information provided regarding Dr. Price's testimony was sufficient to satisfy the Rule 26 requirements. The State provided the subject matter, the factual substance, and a summary of the grounds for Dr. Price's opinion. The State also supplemented Dr. Price's testimony by the deadline for all discovery to be completed. The State supplemented Dr. Price's testimony a second time, after the deadline for discovery passed but before the extended January 25, 2002, deadline for the taking of depositions. Ideally, the State would have provided all supplementation by the discovery deadline. However, the State was attempting to provide as complete a picture as possible regarding Dr. Price's testimony. If his testimony was not comprehensively described in answers to interrogatories, that was in large part due to the District Court's rulings precluding an IME and excluding full access to Kristin's medical records.

In addition, Dr. Price's disclosures were provided before the deadline for all depositions had passed. Any prejudice suffered by Kristin was minimal because she was well-aware Dr. Price was listed as an expert witness and she had ample time to depose him. No surprise is alleged and none occurred. In its scheduling order, the court generally warned that noncompliance with the order's provisions could result in the imposition of sanctions. However, no more specific warning was ever given.

Having reviewed the court's ruling in the context of the three Maloney criteria, we conclude that the court abused its discretion in not allowing Dr. Price to testify. The facts here are distinguishable from Seal v. Woodrows Pharmacy, 1999 MT 247, 296 Mont. 197, 988 P.2d 1230. In that case, we upheld a trial court's prohibition of a doctor's testimony because of continual and blatant discovery abuses when Seal refused to provide the required Rule 26 information even after being afforded numerous opportunities to do so. Seal, ¶ 25. In this case, the State did not engage in continual and blatant discovery abuses. The court should have, at a minimum, allowed Dr. Price to testify based on his review of Kristin's redacted medical records. We reverse the District Court's decision not to allow Dr. Price to testify as an expert witness.

Issue 6: Whether the District Court erred in excluding evidence of (1) stressors in Kristin's life unrelated to the accident and counseling services Kristin received prior to Hunter's accident; and (2) a prior fall at the MSU library?

We review a grant or denial of a motion in limine for an abuse of discretion. Bramble, ¶ 16. The trial court has the inherent power to deny or grant a motion in limine to ensure that a fair trial is afforded to all parties. Bramble, ¶ 16. Litigants must establish a causal connection more probable than not connecting any possible cause of a plaintiff's injuries before alternate causation testimony is allowed at trial; mere speculation is not sufficient and not admissible. Newville v. State, Dept. of Family Svcs. (1994), 267 Mont. 237, 260, 883 P.2d 793, 807.

A district court has broad discretion to determine whether evidence is relevant and admissible, and we will not overturn the district court's decision absent an abuse of discretion. Kissock v. Butte Convalescent Center, 1999 MT 322, ¶ 10, 297 Mont. 307, ¶ 10, 992 P.2d 1271, ¶ 10. A court may exclude relevant evidence if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, needless presentation of cumulative evidence, waste of time, undue delay, or misleading the jury. Rule 403,
¶ 65 In *Kimes v. Herrin* (1985), 217 Mont. 330, 333, 705 P.2d at 108, 110, we stated that it **53** was an abuse of discretion for a trial court to allow testimony suggesting that a plaintiff's home environment may have caused the plaintiff's symptoms because no medical connection was established between the home environment and the appellant's symptoms.

¶ 66 The question of what caused Kristin's symptoms is critical to the issue of her damages. If any information has a tendency to make the alleged cause of the symptoms more or less probable, it would be relevant and admissible, unless otherwise provided by law. *Rules 401 and 402, M.R.Evid.*

**Unrelated Stressors and Prior Counseling**

¶ 67 The District Court, pursuant to Rule 403, M.R.Evid., granted Kristin's motion in limine excluding evidence regarding other life stressors because it would be more prejudicial than probative. The life stressors included Kristin's divorce in 1994, her parents' divorce in 1974, work issues, and child custody issues. The State did not offer an expert opinion that it was more probable than not that prior stressors may have contributed to or were relevant to Kristin's present claims.

¶ 68 Before Hunter's accident, Kristin received brief counseling in 1983 or 1984 and also in 1992. Kristin was able to produce a portion of these counseling records but claims others were unavailable because the counseling occurred so long ago. The State has offered no evidence to dispute this. Kristin also produced some more recent redacted counseling records. The District Court granted Kristin's motion in *326* in limine excluding evidence of this prior unrelated counseling because it was information unrelated to Kristin's case, too remote, irrelevant, and more prejudicial than probative.

¶ 69 On appeal, the State presents a cursory two paragraph argument that it is entitled to discover evidence of any alternative causation for Kristin's claims and that she waived her right to privacy by putting her emotional state at issue in this suit. Kristin placed her mental and physical condition at issue by claiming damages for this type of injury. *Jaap*, 191 Mont. at 322, 623 P.2d at 1391. However, by doing so she has only waived the physician-patient privilege that applies to her mental or physical condition in controversy. *Jaap*, 191 Mont. at 322, 623 P.2d at 1391.

¶ 70 The State did not present expert testimony that established a causal connection between Kristin's present symptoms and the other stressors or the prior counseling records. Absent this more probable than not causal link, the State is not entitled to present alternate causation evidence regarding the other stressors and is also not entitled to any more records than it already has access to. *Kimes, 217 Mont. at 333, 705 P.2d at 110; Newville, 267 Mont. at 260, 883 P.2d at 807*. The State is not entitled to embark upon an unbridled fishing expedition into Kristin's life, spanning years far-removed from the present case, in an attempt to fashion some alternate cause for her current claims. Moreover, the State has not disputed Kristin's assertion that she was unable to access the other counseling records. We affirm the trial court's order precluding the prior counseling records and evidence of other stressors.

**Prior Fall**

[48] ¶ 71 In the event we remand for a new trial, Kristin cross-appeals the motion in limine denying evidence of a prior fall at the same location as Hunter's fall. Because we remand for a new trial on damages, we examine her cross-appeal.

[49][50] ¶ 72 The District Court granted the State's motion in limine excluding evidence of the prior fall. The court concluded the prior fall related only to the duty and breach elements of negligence. It specifically noted that evidence of the prior fall was excluded because the issue of liability had already been fixed and the fall did not relate to Kristin's direct emotional impact. The court stated that the prior fall did not directly contribute to Kristin's emotional distress because shock suffered in a negligent infliction of emotional distress claim must result from a direct emotional impact upon the plaintiff from the *327* sensory and contemporaneous perception of the accident, as compared to learning of the accident from others after its occurrence. However, this reasoning is inconsistent with **54*Sacco v. High Country Independent Press* (1995), 271 Mont. 209, 232, 896 P.2d 411, 425, in which we stated that "[a] cause of action for negligent infliction of emotional distress will arise under circumstances where serious or severe emotional distress to the plaintiff was the reasonably foreseeable consequence of the defendant's negligent act or omission." One is not required to be a bystander at an accident to have a valid claim for emotional distress damages. It is one factor a court can consider but it is not determinative. *Wages v.*
¶ 73 We have recognized that evidence of prior accidents may be offered for various reasons besides proving negligence.  *Kissock*, ¶ 15 (evidence of prior accidents may be admitted to show cause in fact, notice of a condition or defect, the existence or dangerousness of a particular physical condition, and the possibility that a condition might cause an accident similar to the type alleged).  Kristin claims that learning of the prior fall soon after witnessing Hunter's fall contributed to her psychological injuries.  Accordingly, she contends, the prior fall relates to damages as well as duty and breach.  Kristin's learning of the prior fall made her claim of psychological/emotional distress more or less probable.  *Rule 401, M.R.Evid.*  As such, it was relevant to the issue of damages.  To the extent the District Court excluded evidence of the prior fall for the reason that there was no contemporaneous perception, we reverse.  We note, however, that the State also objected to evidence of the other fall as being more prejudicial than probative under Rule 403, M.R.Evid.  That question was not addressed in the proceedings below and is more appropriately left to the discretion of the District Court on remand.

¶ 74 Issue 7: Whether the District Court erred in its jury instructions concerning the claims of emotional distress and loss of established course of life?

[*51][*52][*53][*54][*55][*56]* ¶ 75 A trial court has broad discretion in determining whether to give a proposed jury instruction.  *Christofferson v. City of Great Falls*, 2003 MT 189, ¶ 9, 316 Mont. 469, ¶ 9, 74 P.3d 1021, ¶ 9.  We will not reverse a district court on the basis of its jury instructions absent an abuse of discretion.  *Christofferson*, ¶ 9.  "In reviewing whether a particular jury instruction was properly given or refused, we consider the instruction in its entirety, as well as in connection with other instructions given and with the evidence introduced at trial."  *Christofferson*, ¶ 9*328* (citation omitted).  The party alleging error in a jury instruction must demonstrate prejudice.  *Christofferson*, ¶ 9.  Prejudice will not be found if the jury instructions in their entirety state the applicable case law.  *Christofferson*, ¶ 9.

[*57][*58][*59][*60]* ¶ 76 Montana law provides for monetary compensation to every person who suffers detriment from the unlawful act or omission of another.  Section 27-1-202, MCA.  Emotional distress produces its own unique damages.  Damages can be compensatory (permitted for both intentional and negligent infliction of emotional distress) or punitive (permitted for intentional infliction of emotional distress to address the culpability of a defendant's conduct).  *Sacco*, 271 Mont. at 238, 896 P.2d at 429.  Damages for loss of ability to pursue an established course of life compensate for impairment of the ability to pursue one's chosen pursuits in life, calculated separately from the loss of one's earning capacity.  *Mullery v. Great Northern Ry. Co.* (1915), 50 Mont. 408, 426, 148 P. 323, 328.  Contrary to the State's contention, a claim for the loss of ability to pursue an established course of life need not be premised on a physical limitation.  A plaintiff is "entitled to recover, in the case of permanent injuries, a reasonable compensation for the destruction of his capacity to pursue an established course of life."  *Rasmussen v. Sibert* (1969), 153 Mont. 286, 297, 456 P.2d 835, 841.

¶ 77 In this case, expert medical testimony was introduced at trial which described Kristin's PTSD symptoms.  The expert stated this well-recognized mental injury has physical components, including brain chemistry and hormone level alterations.  PTSD symptoms are a response to an emotional trauma that leads to a physical impact upon the brain.

**§55** ¶ 78 In settling jury instructions on Kristin's claim for negligent infliction of emotional distress, the court reasoned that the heightened standard of severe or serious distress from *Sacco* only applies in cases where there is no physical or mental injury.  Since Kristin suffered PTSD with resulting physical impact, the court concluded the *Sacco* severe or serious standard did not apply.  Accordingly, the court instructed that Kristin only had to prove that she suffered emotional distress or psychological injury as a result of Hunter's fall.  The State contends that the instructions were incorrect because they did not require that the emotional distress meet the severe or serious standard required by *Sacco*, which cited *Restatement 2nd of Torts*, § 46, comment j.  *Sacco*, 271 Mont. at 233, 896 P.2d at 425.

[*61]* ¶ 79 Since we are remanding for a new trial on damages, we take this opportunity to clarify the rule from *Sacco* that emotional distress must *329* be severe or serious.  In cases where there is a physical manifestation of bodily harm resulting from emotional distress, such as PTSD, this bodily harm is sufficient evidence that the emotional distress suffered by the plaintiff is genuine and severe.  As explained in the *Restatement 2nd of Torts*, § 46, comment k, "[n]ormally, severe emotional distress is
accompanied or followed by shock, illness, or other bodily harm, which in itself affords evidence that the distress is genuine and severe." (Emphasis added.) This manifestation assures that only genuine harm, not fraudulent claims, will be compensated.

¶ 80 The State also claims that Kristin is not permitted to recover damages for both loss of ability to pursue an established course of life and damages for emotional distress. However, the State has failed to provide any law supporting this contention. Contrary to the State's claims, no dual recovery has occurred. We have previously recognized claims for emotional distress as separate, independent claims and we continue this rule. Sacco, 271 Mont. at 238, 896 P.2d at 429. Loss of established course of life and emotional distress are two separate and distinct claims with differing elements and different compensable damages. Hence, if supported by the evidence, a separate recovery is allowed for each. Whether the damages overlap is a question of proof. For example, PTSD may or may not impact one's ability to pursue an established course of life.

¶ 81 The court incorrectly instructed the jury regarding emotional distress but correctly instructed regarding loss of established course of life. A jury instruction on emotional distress should state that the severe and serious standard applies and that this standard can be met by proof that emotional distress resulted in shock, illness, or other bodily harm.

¶ 82 Issue 8: Whether the District Court erred in excluding the videotapes of Hunter?


*330 ¶ 84 In this case, the State sought to introduce video footage, as demonstrative evidence, showing Hunter as a well-adjusted child, not suffering from any deficits. The State attempted to introduce this evidence through the testimony of Hunter's grandmother. The District Court refused to allow the evidence because it did not supplement testimony or clarify issues and, as the court noted, the tape did not accurately depict Hunter's life. The tape was edited from hours of home videos showing the best of the best--happy occasions such as birthdays and holidays and fun outdoor activities like swimming.

¶ 85 On appeal, the State argues that because it attempted to introduce the videotape with Hunter's grandmother's testimony that the tape depicted happier moments of Hunter's **56 life, it provided adequate foundation for the tape to be admitted. The State claimed that the tape accurately portrays Hunter as a happy, well-adjusted child. The State sought to introduce the tape to counter Kristin's assertions that, due to Hunter's condition, she suffered emotional distress. The State, however, has failed to establish that the exclusion of the videotape was a manifest abuse of discretion. The videotape fails to satisfy the requirements set out in Ingraham. Ingraham, ¶ 94. Therefore, we affirm the exclusion of the videotape.

¶ 86 Issue 9: Whether the District Court erred in not dismissing jurors for cause?

¶ 87 We review a trial "court's refusal to grant a challenge for cause for an abuse of discretion." Reff-Conlin's, Inc. v. Fireman's Fund Ins. Co., 2002 MT 60, ¶ 16, 309 Mont. 142, ¶ 16, 45 P.3d 863, ¶ 16. We have previously recognized claims for emotional distress as separate, independent claims and we continue this rule. Sacco, 271 Mont. at 238, 896 P.2d at 429. Loss of established course of life and emotional distress are two separate and distinct claims with differing elements and different compensable damages. Subrogation of the State's claims, no dual recovery has occurred. We have previously recognized claims for emotional distress as separate, independent claims and we continue this rule. Sacco, 271 Mont. at 238, 896 P.2d at 429.

¶ 88 In order to ensure against bias, the District Court interviewed the eight jurors who had read the article. One juror who stated that he was not sure if he could keep the prior fall out of his mind was excused for cause. The other seven jurors stated they could keep an open mind and fairly decide the case. The State has not demonstrated that any of these remaining jurors had a state of mind "evincing enmity against or bias in favor of either party[.""] was satisfied because several jurors, days before the trial, saw a local newspaper article that mentioned the prior fall.

¶ 89 The only case the State relies on in support of its argument is Reff-Conlin's, Inc. In that case, we determined that a juror should have been excluded.
because of the existence of a debtor-creditor *331 relationship, satisfying another, more specific, statutory grounds for challenge. Reff-Conlin's, Inc., ¶ 21. That case is factually dissimilar to the case at bar because no specific grounds for challenge for cause have been established. The State has not shown that the District Court abused its discretion in denying the challenges for cause. We affirm.

¶ 90 In conclusion, we reverse and remand for a new trial on damages in light of our rulings on issues three, five, and six.

We concur: JIM RICE, Justice.

Justice JOHN WARNER Concurring and Dissenting.

¶ 91 I concur in Issues 1-5 and 7-9. Relating to Issue 6, I also agree that evidence of the prior fall of another child at the MSU Library, if such were admissible, would be subject to a discretionary Rule 403, M.R.Evid., analysis.

¶ 92 However, ordering that the evidence of the prior fall may be admitted, not to prove fault or causation, but damages, is a serious mistake. As noted in the Court's opinion, it is true that Sacco and Wages stand for the propositions that a claim for negligent infliction of emotional distress will arise where serious or severe emotional distress was a reasonably foreseeable consequence of a defendant's negligence, and that the plaintiff does not have to be a bystander to have a valid claim. However, these are not the issues presented by the facts here. Here, the majority of this Court takes a giant leap forward in the law and determines that when a person is negligent, as the State apparently was in the instance of the prior fall, it is foreseeable that other persons who observe the results of a subsequent, separate negligent act or omission may suffer increased damages, actually caused by the first incident, because their already severe emotional damages are increased when they hear of such prior negligence. Thus, we may now have changed the law in Montana and held that it is foreseeable that an act or omission constituting negligence may result in damages owed to other, as yet uninjured persons, for an indefinite time in the future. We have held that such initial negligence may be admissible, along with other subsequent negligent acts or omissions, as evidence of emotional damages, even though such do not arise from the same accident or even concern the same injured person. And, the person **57 claiming such damages need not have any relationship with or connection to the person actually injured in the first incident. A subsequent negligent act or omission which causes emotional damage could somehow be deemed to be the cause of the damage really suffered as a result of the first negligent act or omission.

¶ 93 To summarize what is apparently the new rule, with which I *332 emphatically disagree, in Montana, a person who is negligent has a duty, and by his negligence has already breached that duty, to all other persons who in the future may suffer an increase in their emotional distress because of such negligent act or omission. Cause is established when the subsequently severely emotionally damaged person learns of the prior negligence, and all that has to be proven is damages. Further, the prior act apparently need not be included in the pleadings even though it is the cause of damages.

¶ 94 Where will it end? As Schultz's Charlie Brown is wont to say; Good Grief! Kristin deserves the damages she suffered as a result of Hunter's accident, not every other stairway accident on campus. I dissent from this Court's Opinion that evidence of the prior fall may be admitted if the District Court finds that its evidentiary value is not outweighed by its prejudice to the State.

Chief Justice KARLA M. GRAY joins in the foregoing concurrence and dissent.

Justice PATRICIA O. COTTER concurring in part and dissenting in part.

¶ 95 I concur in the Court's disposition of Issues 1, 2, 3(2), 4, 6, and 7 through 10. I dissent from the Court's disposition of Issues 3(1) and 5. I would affirm the verdict and judgment of the District Court.

¶ 96 Issue 3(1) presents the question of whether the District Court abused its discretion when it denied the defendants' request for the production of all of Kristin's medical and mental health records. As the Court points out, the District Court entered its Order following an in camera inspection of the medical and mental health care records in question. ¶ 37. We have consistently upheld the use of the in camera review as a tool that effectively protects both parties. See Burns, 253 Mont. at 39, 830 P.2d at 1319-20; State v. Thiel (1989), 236 Mont. 63, 768 P.2d 343; State v. Mix (1989), 239 Mont. 351, 781 P.2d 751; and In re Lacy (1989), 239 Mont. 321, 780 P.2d 186. As we stated in Burns, "[p]rohibiting discovery of materials that are not probative is one of the functions of trial judges which is within their discretionary..."
powers."  \textit{Burns, 253 Mont. at 43, 830 P.2d at 1322.}

I would conclude that the District Court judge properly conducted an \textit{in camera} review under the circumstances presented in this case, and that, in concluding from his review that the subject records were "... subject to strong constitutional protections, are irrelevant to the issues in this case, and are not discoverable," he performed precisely the function we have historically endorsed.  We do not disturb the rulings of the district court absent an abuse of discretion.  \textit{Burns, 253 Mont. at 42, 830 P.2d at 1322.}

I see nothing in the record before us that establishes an abuse of discretion \textit{*333} in the District Court's handling of the disputed medical records.  I would therefore affirm on this issue.

\section{¶ 97}  I would also affirm the District Court's decision prohibiting the State from conducting an IME and excluding the testimony of the State's expert witness.  (Issue 5).  We review such a ruling to determine whether the district court abused its discretion.  \section{¶ 51}  I would conclude that no abuse of discretion was shown.

\section{¶ 98}  In denying the State's request for an IME, the District Court found, based upon the medical records, that the State had known of Kristin's PTSD since September, 1997.  It therefore rejected the State's contention that her disclosure of the condition in late 2001 was a surprise.  This Court concludes at ¶ 55 that the early disclosure of the records containing the PTSD diagnosis was insufficient notice that Kristin intended to use the diagnosis as a basis for her damages claim.  This is entirely too fine a distinction for us to draw, especially when applying an abuse of discretion standard of review.  The fact is, as the State conceded in its brief opposing reconsideration of the IME issue, the State was aware early in the proceedings \textit{**58} that Kristin was claiming she suffered from emotional distress, depression and anxiety, and emotional disturbance, as a result of her son's fall and injuries.  The medical records contained the technical diagnosis.  It seems to me, and it apparently seemed to the District Court as well, that this combination of disclosures, given well in advance of the discovery deadlines, provided the State with ample time and notice to arrange for an IME prior to the deadline for disclosure of expert witnesses.

\section{¶ 99}  While the Court may feel that greater latitude should have been shown by the District Court, it is not our function to overturn a discretionary ruling that is supported by the facts in the record.  I would uphold the District Court's exercise of discretion on this issue.

\section{¶ 100}  Finally, I would affirm the District Court's refusal to allow Dr. Price to testify.  The District Court's scheduling order required the filing of a "comprehensive statement of the proposed expert's testimony" and "a comprehensive statement" of the grounds for the expert's opinion, on or before November 15, 2001.  Dr. Price's disclosure of November 15, 2001, did not list any opinion, much less any grounds for an opinion.  The supplementary response was not filed until a month later.  Given these circumstances, the District Court was well within its discretion to strike Dr. Price's testimony.  We have consistently held that it is within the district court's discretion to impose sanctions for the failure to comply with a court's scheduling orders.  \textit{*334 McKenzie v. Scheeler (1997), 285 Mont. 500, 506, 512, 949 P.2d 1168, 1172, 1175.}  This is what the District Court did.  There was no abuse of discretion.

\section{¶ 101}  For the foregoing reasons, I would affirm the District Court's disposition of the matters raised in Issues 3(1) and 5, and would affirm the judgment of the District Court.  I dissent from our refusal to do so.

Justice \textbf{JAMES C. NELSON} and Justice \textbf{JIM REGNIER} join in the concurrence and dissent of Justice \textbf{PATRICIA O. COTTER}.

319 Mont. 307, 84 P.3d 38, 2004 MT 20

END OF DOCUMENT

District Judge, Respondent.

No. 01-536.


In prosecution for driving under the influence (DUI), the 21st Judicial District Court, Jeffrey H. Langton, J., suppressed test result for blood sample drawn from motorist at hospital upon order of physician for purposes of medical diagnosis and treatment. State and Attorney General petitioned for writ of supervisory control. The Supreme Court held that: (1) implied consent statute regarding blood samples obtained at request of law enforcement officials was inapplicable, though motorist had refused officer's request for blood sample before physician ordered blood test, and (2) remand was necessary, for determination whether the blood test result was competent evidence.

Reversed and remanded.

Trieweiler, J., filed an opinion concurring in part and dissenting in part.

West Headnotes

[1] Criminal Law
Where the facts are not in dispute, appellate review of a district court's ruling on a motion to suppress is plenary as to whether the district court correctly interpreted and applied the law.

[2] Courts
Issuance of a writ of supervisory control is appropriate when a district court is proceeding based on a mistake of law which, if uncorrected, would cause significant injustice, and where the remedy by appeal is inadequate. Const. Art. 7, § 2(2); Rules App.Proc., Rules 17(a).

[3] Courts
It was appropriate to issue writ of supervisory control, as to district court's suppression of blood test results obtained by medical authorities for emergency treatment of motorist at hospital, after motorist had refused to consent to blood test pursuant to police officer's request under implied consent statute; district court was proceeding under mistake of law in believing that implied consent statute was applicable to motorist's case, and if district court's mistake of law was left uncorrected, State would be without adequate remedy on appeal. Const. Art. 7, § 2(2); MCA 61-8-402(4,10); Rules App.Proc., Rules 17(a).

Implied consent statute, governing consensual collection, pursuant to request from peace officer, of blood or breath test samples from persons arrested for driving under the influence of alcohol or drugs (DUI), did not apply to blood test results obtained by medical authorities for emergency treatment at hospital, after motorist had refused to consent to blood test pursuant to police officer's request under implied consent statute. MCA 61-8-402(4,10).

Administrative rule requiring that a blood sample collected for drug and/or alcohol analysis, regarding a motorist arrested for driving under the influence (DUI), must be collected "upon written request of a peace officer or officer of the court" does not apply to a blood test conducted for medical treatment purposes. MCA 61-8-402; Mont.Admin.R. 23.4.220(1).
by medical authorities for emergency treatment purposes when Llewellyn refused to consent to a blood test pursuant to a police officer's request under Montana's implied consent statute?

¶ 5 We assume supervisory control, reverse the District Court's Order granting Llewellyn's motion to suppress and remand for further proceedings.

BACKGROUND

¶ 6 On September 28, 2000, Llewellyn allegedly rear-ended another vehicle stopped at a red light at the intersection of Eastside Highway and Highway 93 in Ravalli County. Llewellyn, who suffered significant injuries as a result of the accident, refused to submit to a breath test at the scene. She was then transported to the emergency room of the Community Medical Center in Missoula County for treatment. While undergoing treatment, Llewellyn was asked by a Montana highway patrol officer to provide a blood sample for analysis pursuant to § 61-8-402, MCA (1999). Llewellyn refused and her refusal was documented by the officer. However, during the course of emergency room treatment, blood was drawn from Llewellyn upon the order of a physician for purposes of medical diagnosis and treatment. The lab tests revealed a blood alcohol content above the legal allowable limit. The results were obtained by the prosecution pursuant to an investigative subpoena.

¶ 7 Llewellyn filed a motion to suppress the admission of the blood test obtained for medical diagnosis and treatment purposes claiming that the State could not show compliance with the required administrative procedures in the collection of the blood test for evidentiary purposes; and that she withdrew her consent to a blood test. The State responded and contended that blood tests taken for medical diagnosis and treatment purposes are admissible as "other competent evidence" pursuant to our decision in State v. Devlin (1999), 285 Mont. 84, 946 P.2d 134, and § 61-8-404, MCA (1999). The District Court granted Llewellyn's motion concluding our decision in Devlin was distinguishable from the case at hand since the defendant in Devlin consented to a blood test unlike Llewellyn; and thus, admitting Llewellyn's blood test results obtained for medical treatment purposes would "render null and void her right to refuse consent" provided by § 61-8-402(4), MCA (1999). The District Court then concluded that "other competent evidence" could include eye witness testimony concerning Llewellyn's manner of driving, appearance, gait, breath smell, etc., but could not include blood analysis for medical treatment purposes when Llewellyn had previously exercised her statutory right and refused to submit to a blood test for purposes of determining her blood alcohol content ("BAC"). The District Court concluded that to allow the admission of such evidence would permit an end run around the implied consent statutes which the Montana Legislature could not have intended. The District Court did not address whether applicable administrative procedures were followed in collecting Llewellyn's blood test. Subsequently, the State filed the petition for writ of supervisory control before us contending that the District Court's order of suppression is directly contrary to our decision in Newill.

*494 STANDARD OF REVIEW

[1] ¶ 8 Where the facts are not in dispute, our review of a district court's ruling on a motion to suppress is plenary as to whether the district court correctly interpreted and applied the law. State v. Devlin, 1999 MT 90, ¶ 7, 294 Mont. 215, ¶ 7, 980 P.2d 1037, ¶ 7 (citation omitted).

DISCUSSION

ISSUE 1

¶ 9 Whether we should exercise jurisdiction in this matter?

[2][3] ¶ 10 Supervisory control is appropriate when a "district court is proceeding based on a mistake of law which, if uncorrected, would cause significant injustice, and where the remedy by appeal is inadequate." Park v. Montana Sixth Judicial District Court, 1998 MT 164, ¶ 13, 289 Mont. 367, ¶ 13, 961 P.2d 1267, ¶ 13. Given the State's limited ability to appeal an evidentiary ruling, we have previously exercised supervisory control to prevent the introduction of evidence where correction of the ruling by a later court decision would be ineffective. State ex rel. Mazurek v. District Court of Montana Fourth Judicial District (1996), 277 Mont. 349, 353, 922 P.2d 474, 477. As subsequently discussed herein, we conclude that the District Court is proceeding under a mistake of law. Additionally, if the District Court's mistake of law is left uncorrected, the State would be without an adequate remedy on appeal. Accordingly, we grant the State's petition and accept original jurisdiction over this matter pursuant to Article VII, Section 2(2), Montana Constitution, and Rule 17(a), M.R.App.P.

ISSUE 2

¶ 11 Whether the District Court erred in suppressing Llewellyn's blood test results obtained by medical authorities for emergency treatment purposes when
Llewellyn refused to consent to a blood test pursuant to a police officer's request under Montana's implied consent statute?

**823** [4] ¶ 12 Section 61-8-402, MCA (1999), commonly known as Montana's implied consent statute, governs the consensual collection of blood or breath test samples from persons arrested for driving under the influence of alcohol or drugs pursuant to a request from a peace officer. Subsection (10) expressly states that "[t]his section does not apply to blood ... tests, samples, and analyses used for purposes of medical treatment or care of an injured motorist...." In Newill we specifically addressed the applicability of Montana's implied consent laws relative to blood drawn for medical diagnosis and treatment of an injured motorist and concluded § 61-8-402, MCA (1995), does not apply to **495** blood tests taken for medical treatment purposes.

¶ 13 The Defendant in Newill suffered head injuries in an automobile accident. During treatment at the hospital, the attending physician took a blood sample for diagnostic and treatment purposes as part of normal hospital procedure. Newill had previously consented to a blood sample under implied consent procedures when requested by an officer, but was medically unable to give one. Evidence of Newill's blood analysis taken by the physician was admitted into evidence and Newill appealed. Newill contended that the blood samples taken for medical purposes should not be admitted as evidence of her blood alcohol content.

¶ 14 We determined in Newill that the Montana Legislature had provided evidentiary provisions for the admissibility of blood tests taken for medical treatment purposes in § 61-8-404(1)(a), MCA (1995), which provides "evidence of any measured amount or detected presence of alcohol or drugs in the person at the time of the act alleged, as shown by an analysis of the person's blood ... is admissible"; and § 61-8-404(3), MCA (1995), which states that "[t]he provisions of this part do not limit the introduction of any other competent evidence bearing on the question of whether the person was under the influence of alcohol...." Newill, 285 Mont. at 88-89, 946 P.2d at 136-137. We also determined that the foundational requirements of § 61-8-404(1)(b), MCA (1995), were inapplicable to blood tests taken for medical treatment purposes since those requirements applied only to tests administered pursuant to § 61-8-402, MCA (1995). Newill, 285 Mont. at 89, 946 P.2d at 137. Then, the only question left for us to determine in Newill was whether the blood test taken at the hospital pursuant to a request by Newill's treating physician was admissible as "other competent evidence" under § 61-8-404(3), MCA (1995). Accordingly, we examined the skills of the medical personnel involved and concluded that the blood test was admissible as other competent evidence bearing on whether Newill was under the influence of alcohol. Newill, 285 Mont. at 89, 946 P.2d at 137.

¶ 15 We point out that § 61-8-404(1)(a), MCA (1995), was amended in 1999 substituting the language stating "the act alleged" to "a test". In addition, § 61-8-404(1)(b), MCA (1995), was amended in 1997, deleting the provision "administered under 61-8-402". Section 61-8-404(1)(b), MCA (1999), states "a report of the facts and results of one or more tests of a person's blood or breath is admissible in evidence if...." Consequently, the foundational requirements of § 61-8-404(1)(b)(ii), MCA (1999), and § 61-8-405(1), MCA (1999), as necessitated by the **496** competency requirement of § 61-8-404(1)(b)(ii), MCA (1999), are applicable to the case at hand.

¶ 16 Although the statute was amended, the resolution of this petition is controlled by our decision in Newill. While it is true, as the District Court correctly recognized, that Newill did provide consent to the officer to have a blood sample taken for determining her BAC and Llewellyn did not, the criteria for admissibility under § 61-8-402, MCA (1999), relating to blood tests administered under the implied consent statute are inapplicable to diagnostic blood tests taken by a hospital or treating physician. Therefore, we see no legally relevant distinction between the facts presented here and the facts we confronted in Newill. We thus conclude that the District Court's order of suppression conflicts with our decision in Newill.

[5] ¶ 17 Here, there are additional competency requirements, arising from the 1997 amendment to § 61-8-404, MCA (1995), that **824** were not at issue in Newill. The foundational requirements of § 61-8-404(1)(b)(ii), MCA (1999), and § 61-8-405(1), MCA (1999), must be applied to the case at hand to ascertain competency of the evidence. We note that the administration of a blood test for medical treatment purposes need not be conducted at the request of a peace officer as required by § 61-8-405(1), MCA (1999), since such a requirement is only applicable to blood tests conducted pursuant to § 61-8-402, MCA (1999), whereby § 61-8-402(2)(a), MCA (1999), requires that blood tests administered

pursuant to that section "must be administered at the direction of a peace officer". Further, a defendant charged with driving under the influence of alcohol is entitled to procedural safeguards contained in the Administrative Rules of Montana. See State v. Incashola, 1998 MT 184, ¶ 8, 289 Mont. 399, ¶ 8, 961 P.2d 745, ¶ 8 (citation omitted). Accordingly, the Administrative Rules of Montana, specifically Rule 23.4.220, ARM, regarding the collection of blood samples for drug and/or alcohol analysis must be applied to the case at hand to determine if the blood test is competent evidence. However, the requirement of Rule 23.4.220(1), ARM, that a blood sample be collected "upon written request of a peace officer or officer of the court" does not apply to a blood test conducted for medical treatment purposes, as that requirement applies to blood tests conducted pursuant to § 61-8-402, MCA (1999).

¶ 18 Hence, the question remaining is whether the medical blood test taken for medical treatment purposes is "competent" evidence for purposes of admissibility under § 61-4-404(3), MCA (1999). The District Court made no determination whether the evidence was *497 competent pursuant to the requirements of § 61-8-404(1)(b)(ii), MCA (1999), § 61-8-405, MCA (1999), and the Administrative Rules of Montana. Consequently, we are unable to reach a determination of the question presented by § 61-4-404(3), MCA (1999). Thus, we remand this case for such determination by the District Court. Therefore,

¶ 19 IT IS HEREBY ORDERED that the petition for writ of supervisory control is GRANTED and that this case is remanded for further proceedings consistent with this Opinion.

¶ 20 The Clerk of Court is directed to mail a copy of this Order to all counsel of record and the Honorable Jeffrey H. Langton.

/s/ Karla M. Gray
Chief Justice

/s/ Jim Regnier

/s/ James C. Nelson
/s/ Patricia Cotter

/s/ W. William Leaphart
/s/ Jim Rice

Justices

Justice TERRY N. TRIEWEILER concurring in part and dissenting in part.

¶ 21 I concur with that part of the majority opinion which concludes that the foundational requirements found at § 61-8-404(1)(b)(ii), MCA (1999), and § 61-8-405(1), MCA (1999), are applicable to evidence of blood alcohol content regardless of whether the source is blood drawn pursuant to § 61-8-402, MCA, or for purposes of medical treatment. I would add that compliance with applicable administrative regulations is also necessary.

¶ 22 I dissent from that part of the majority opinion which concludes that blood test results obtained by medical providers are admissible to prove operation of a motor vehicle while under the influence of alcohol or drugs even though the motorist from whom the blood was drawn refused to submit to similar tests when requested to do so by a peace officer and suffered the consequences of that refusal. I would affirm the District Court and reverse our prior decision in State v. Newill (1997), 285 Mont. 84, 946 P.2d 134.

¶ 23 I conclude that § 61-8-402, MCA, requires consent of a driver suspected of operating a motor vehicle under the influence of alcohol before tests can be administered to prove the presence of alcohol or drugs in a person's body. The consequences for denying that refusal are set forth in § 61-8-402(4), MCA. To hold, as the majority has done, that the consent requirement can be circumvented by going to the hospital and subpoenaing records of blood test results drawn without the driver's consent renders the procedural requirements in § 61-8-402, MCA, and the sanctions that it provides for *498 failure to give consent meaningless. I would also conclude that the provision in subparagraph (10) which provides that this section does not apply to blood drawn for *498 purposes of medical treatment refers to the assumption of consent provided for in subparagraph (1) and the sanctions for withdrawal of that assumed consent in subparagraph (4). To interpret subparagraph (10) as the majority does renders the statute internally inconsistent.

¶ 24 Finally, I disagree that § 61-8-404(3), MCA, provides any comfort to the majority's position. Section 61-8-404, MCA, has simply been enacted to provide that the blood or breath evidence consented to in § 61-8-402, MCA, is admissible in a judicial proceeding if the prescribed procedures are followed and the necessary foundation for admissibility is laid. Subparagraph (a) refers to any evidence of the
measured amount of alcohol or drugs present and subparagraph (b) refers to a report of blood or breath test results. All of §61-8-404, MCA, other than subparagraph (3), refers to blood or alcohol tests for the presence of alcohol in a person's body. Therefore, when subparagraph (3) refers to "any other competent evidence," it necessarily refers to evidence other than breath or blood tests. For that reason, it cannot serve the purpose for which it is used by the majority.

¶ 25 Therefore, I dissent from that part of the majority opinion which construes §§61-8-402 and -404, MCA, to permit the admission of blood test results taken for purposes of medical treatment from a motorist who has declined to submit to testing which would measure the presence of alcohol in that person's body and has already suffered the consequences for that refusal.
Health care providers brought state constitutional challenge to statute requiring pre-viability abortions to be performed by physicians. The District Court, Lewis and Clark County, Jeffrey M. Sherlock, J., granted a preliminary injunction that was limited in scope to one physician and one physician's assistant. State appealed. The Supreme Court, Nelson, J., held that: (1) as a matter of first impression, the health care providers had standing to assert the state constitutional privacy rights of women patients; (2) a woman's right to obtain a pre-viability abortion from a health care provider of her choice was protected by the personal autonomy component of the state constitutional right to privacy; and (3) the state did not show a compelling interest for requiring pre-viability abortions to be performed by physicians and not by medically competent physician's assistants.

Affirmed.

Gray, J., specially concurred and filed an opinion in which Turnage, C.J., joined.

West Headnotes

[1] Appeal and Error 174
30k174 Most Cited Cases
Appellate court would consider the standing of health care providers who performed pre-viability abortion services or who provided counseling and referrals related to such services to assert the state constitutional privacy rights of women patients, though the standing issue had not been raised in the trial court, where the case involved important first impression issues in the state regarding access to abortion services. Const. Art. 2, § 10.

30k174 Most Cited Cases
An issue regarding standing is an exception to the general rule that the appellate court will decline to address on appeal an issue not raised by the parties.

[3] Constitutional Law 42.2(1)
92k42.2(1) Most Cited Cases
Individual health care providers who performed pre-viability abortion services or who provided counseling and referrals related to such services, and institutional health care provider that employed such individual providers, had standing to assert the state constitutional privacy rights of women patients, where the challenged statutes were directed at health care providers but they directly interdicted the normal functioning of the physician-patient relationship by criminalizing certain procedures. Const. Art. 2, § 10; MCA 37-20-103, 50-20-109(5, 6).

92k82(7) Most Cited Cases
Because the right to privacy is explicit in the Declaration of Rights of Montana's Constitution, it is a fundamental right. Const. Art. 2, § 10.

[5] Constitutional Law 82(7)
92k82(7) Most Cited Cases
Legislation infringing the exercise of the state constitutional right to privacy must be reviewed under a strict-scrutiny analysis, and thus, the legislation must be justified by a compelling state interest and must be narrowly tailored to effectuate only that compelling interest. Const. Art. 2, § 10.

92k82(7) Most Cited Cases
State constitutional right to privacy was intended by the delegates to Montana's 1972 Constitutional Convention to protect citizens from illegal private action and from legislation and governmental practices that interfere with the autonomy of each individual to make decisions in matters generally considered private. Const. Art. 2, § 10.

[7] Constitutional Law 82(7)
92k82(7) Most Cited Cases
While it may not be absolute, no final boundaries can be drawn around the personal autonomy component of the state constitutional right of individual privacy; it is, at one and the same time, as narrow as is
necessary to protect against a specific unlawful infringement of individual dignity and personal autonomy by the government, and as broad as are the state's ever innovative attempts to dictate in matters of conscience, to define individual values, and to condemn those found to be socially repugnant or politically unpopular. Const. Art. 2, § 10.

98 Constitutional Law 82(7) 92k82(7) Most Cited Cases
The personal autonomy component of the state constitutional right to privacy broadly guarantees each individual the right to make medical judgments affecting her or his bodily integrity and health in partnership with a chosen health care provider, free from government interference. Const. Art. 2, § 10.

99 Constitutional Law 82(10) 92k82(10) Most Cited Cases
A woman's right to obtain a pre-viability abortion from a health care provider of her choice is protected by the personal autonomy component of the state constitutional right to privacy. Const. Art. 2, § 10.

100 Constitutional Law 82(10) 92k82(10) Most Cited Cases
A woman's right to choose to have an abortion before fetal viability and to obtain it without "undue interference" or "undue burden" from the state is protected under the federal Constitution, and is grounded in privacy and protected by the Due Process Clause. U.S.C.A. Const.Amend. 14.

101 Constitutional Law 82(7) 92k82(7) Most Cited Cases
Where the right of individual privacy is implicated, Montana's Constitution affords significantly broader protection than does the federal Constitution. Const. Art. 2, § 10.

102 Constitutional Law 82(7) 92k82(7) Most Cited Cases
The state Constitution requires more than that the state simply not impose an undue burden on a person's exercise of his or her right of individual privacy; rather, under the state Constitution, the government must demonstrate a compelling state interest for infringing this right. Const. Art. 2, § 10.

103 Constitutional Law 82(10) 92k82(10) Most Cited Cases
If the right to privacy under the state Constitution includes anything, it includes the decision of a woman whether or not to beget or bear a child, and it encompasses a woman's choice of whether not to end her pregnancy. Const. Art. 2, § 10.

104 Constitutional Law 82(10) 92k82(10) Most Cited Cases
The rejection of an attempt, at Montana's 1972 Constitutional Convention, to confer constitutionally protected status on a fetus at the time of conception did not preclude a finding that the state constitutional right to privacy protected women's right to obtain pre-viability abortions. Const. Art. 2, § 10.

105 Constitutional Law 82(10) 92k82(10) Most Cited Cases
Implicit in the right of procreative autonomy under the state constitutional right to privacy is a woman's moral right and moral responsibility to decide, up to the point of fetal viability, what her pregnancy demands of her in the context of her individual values, her beliefs as to the sanctity of life, and her personal situation. Const. Art. 2, § 10.

106 Abortion and Birth Control 0.5 4k0.5 Most Cited Cases
The state has no more compelling interest or constitutional justification for interfering with the exercise of the right of procreative autonomy if the woman chooses to terminate her pre-viability pregnancy than it would if she chose to carry the fetus to term. Const. Art. 2, § 10.

107 Constitutional Law 82(7) 92k82(7) Most Cited Cases
Few matters more directly implicate personal autonomy and individual privacy than medical judgments affecting one's bodily integrity and health.

108 Constitutional Law 82(7) 92k82(7) Most Cited Cases
The right of choice in making personal health care decisions and in exercising personal autonomy under the state constitutional right of privacy is not without limits; in narrowly defined instances the state, by clear and convincing evidence, may demonstrate a compelling interest in and obligation to legislate or regulate to preserve the safety, health, and welfare of
a particular class of patients or the general public from a medically-acknowledged, bona fide health risk. Const. Art. 2, § 10.

[19] Constitutional Law 82(7) 92k82(7) Most Cited Cases
When the legislature thrusts itself into the constitutionally-protected zone of individual privacy under the guise of protecting the patient's health, but in reality does so because of prevailing political ideology and the unrelenting pressure from individuals and organizations promoting their own beliefs and values, then the state's infringement of personal autonomy is not only constitutionally impermissible under the right to privacy, it is, as well, intellectually and morally indefensible. Const. Art. 2, § 10.

[20] Constitutional Law 82(7) 92k82(7) Most Cited Cases
Except in the face of a medically-acknowledged, bona fide health risk, clearly and convincingly demonstrated, the legislature has no interest, much less a compelling one, to justify its interference with an individual's fundamental privacy right to obtain a particular lawful medical procedure from a health care provider that has been determined by the medical community to be competent to provide that service and who has been licensed to do so. Const. Art. 2, § 10.

[21] Health 192 198hk192 Most Cited Cases
(Formerly 299k1 Physicians and Surgeons)
Legal standards for medical practice and procedure cannot be based on political ideology, but, rather, must be grounded in the methods and procedures of science and in the collective professional judgment, knowledge, and experience of the medical community acting through the state's medical examining and licensing authorities.

[22] Abortion and Birth Control 1.30 4k1.30 Most Cited Cases

[23] Constitutional Law 82(10) 92k82(10) Most Cited Cases
State did not demonstrate compelling interest for requiring pre-viability abortions to be performed by physicians and not by medically competent physician's assistants, as required under state constitutional right to privacy. Const. Art. 2, § 10; MCA 37-20-103, 50-20-109(5, 6).

[24] Constitutional Law 83(1) 92k83(1) Most Cited Cases
It was irrelevant that statute requiring pre-viability abortions to be performed by physicians may have been narrowly drawn, where the state did not demonstrate a compelling interest for such a restriction, as required under state constitutional right to privacy. Const. Art. 2, § 10; MCA 37-20-103, 50-20-109(5, 6).

[25] Constitutional Law 82(7) 92k82(7) Most Cited Cases
[25] Constitutional Law 82(10) 92k82(10) Most Cited Cases
[25] Constitutional Law 83(1) 92k83(1) Most Cited Cases
The government can demonstrate no compelling interest for legislating on the basis of any sectarian doctrine nor may the state infringe individual liberty and personal autonomy because of majoritarian demands to safeguard some intrinsic value unrelated to the protection of the rights and interests of persons with constitutional status.

[26] Constitutional Law 84.1 92k84.1 Most Cited Cases
The fundamental right to personal and procreative autonomy and, in the broader sense, to individual privacy, prohibits the government from dictating, approving, or condemning values, beliefs, and matters ultimately involving individual conscience, where opinions about the nature of such values and beliefs are seriously divided, where at their core such values and beliefs reflect essentially religious convictions that are fundamental to moral personality, and where the government's decision has a greatly disparate impact on the persons whose individual beliefs and personal commitments are displaced by the state's legislated values. Const. Art. 2, § 10.
The doctrine of separation of church and state makes theology an impermissible basis on which to make law or interpret the federal or state Constitution.

Those in government who make, execute, and interpret the law and who are sworn to support, protect, and defend the Constitution may not, except in violation of their oaths of office, succumb to the pressure of those who would engraft the sectarian tenets and personal values of some onto the laws which govern all.

Respect for the dignity of each individual, a fundamental right protected by the state Constitution, demands that people have for themselves the moral right and moral responsibility to confront the most fundamental questions about the meaning and value of their own lives and the intrinsic value of life in general, answering to their own consciences and convictions.

Equal protection requires that people have an equal right to form and to follow their own values in profoundly spiritual matters.

State constitutional guarantee to each person of the inalienable right to seek safety, health and happiness in all lawful ways includes the right to seek and obtain medical care from a chosen health care provider and to make personal judgments affecting one's own health and bodily integrity without government interference.
Justice JAMES C. NELSON delivered the Opinion of the Court.


Introduction
Standing

¶ 2 The core constitutional right which is under attack in the case at bar is the fundamental right of individual privacy guaranteed by Article II, Section 10, of the Montana Constitution. Quite simply, the statutory amendments at issue prevent a woman from obtaining a lawful medical procedure--a pre-viability abortion--from a health care provider of her choosing. In so doing, these amendments unconstitutionally infringe a woman's right to individual privacy under Montana's Constitution.

FN1 In the context of this opinion, we use the generic term "health care provider" to refer to any physician, physician assistant-certified, nurse, nurse-practitioner or other professional who has been determined by the appropriate medical examining and licensing authority to be competent by reason of education, training or experience, to perform the particular medical procedure or category of procedures at issue or to provide the particular medical service or category of services which the patient seeks from the health care provider.

FN2 In all instances, the plaintiffs brought suit on their own behalf as well as on behalf of their patients. Thus, we are faced with a threshold question: Do the plaintiff health care providers have standing to assert the privacy rights of their women patients? We conclude that they do.

¶ 3 Before we begin our substantive discussion setting forth our rationale for this conclusion, we must first note the obvious. Plaintiffs Armstrong, Cahill, Polstein and Opper are not women who were prevented from obtaining a pre-viability abortion. Rather, they are health care providers who perform such abortion services, or who provide counseling and referrals related to such services. Plaintiff Blue Mountain Clinic, an institutional health care provider, employs Polstein and Opper. In all instances, the plaintiffs brought suit on their own behalf as well as on behalf of their patients. Thus, we are faced with a threshold question: Do the plaintiff health care providers have standing to assert the privacy rights of their women patients? We conclude that they do.

¶ 4 Standing was not raised by the parties. Rather, this case was briefed and argued to the District Court and to this Court on appeal on the basis that the statutory amendments either did or did not violate women's constitutional right to privacy. Presented in that posture, we would, as a general rule, decline to address on appeal an issue not raised by the parties. See Custody of N.G.H. (1998), 1998 MT 212, ¶ 19, 290 Mont. 426, ¶ 19, 963 P.2d 1275, ¶ 19. Standing, however, is an exception to that rule. See Matter of Paternity of Vainio (1997), 284 Mont. 229, 235, 943 P.2d 1282, 1286 (identifying standing as a "threshold requirement of every case"); Rieman v. Anderson (1997), 282 Mont. 139, 144, 935 P.2d 1122, 1125 (stating that objections to standing cannot be waived and may be raised by the court sua sponte).

¶ 5 Moreover, since this case involves important issues of first impression in Montana, our failure to raise and to address standing may leave open to further challenge via that argument the constitutional rights at issue. We are not willing to leave that stone unturned, and, *365 therefore, choose to articulate the rationale which makes it appropriate that we decide this case on the basis that it was presented to us.

¶ 6 In the context of challenges to government action, we have stated that the following criteria must be satisfied to establish standing: (1) The complaining party must clearly allege past, present or threatened injury to a property or civil right; and (2) the alleged injury must be distinguishable from the injury to the public generally, but the injury need not be exclusive to the complaining party. See Olson v. Department of Revenue (1986), 223 Mont. 464, 470, 726 P.2d 1162, 1166 (concluding that the appellants lacked standing to challenge the constitutionality of statutes requiring county residency to run for county office, or obtain a hunting or fishing license, where the record reflected that they had not attempted to run for office or obtain hunting or fishing licenses); Lee v. State (1981), 195 Mont. 1, 7, 635 P.2d 1282, 1285 (concluding that the appellant, as a licensed Montana motorist, was directly affected by 55-mile-an-hour speed limit law, and therefore had standing to challenge its constitutionality although the law...
generally applied to all motorists).

**369 ¶** 7 Although we followed Lee in *Helena Parents v. Lewis & Clark County* (1996), 277 Mont. 367, 922 P.2d 1140, we also extensively relied on numerous United States Supreme Court decisions in articulating whether a parent's organization had standing to challenge a county and school district's investment practices that allegedly violated state law. In concluding that the organization had standing, we effectively broadened the second prong of the above two-part rule to include harm that is common to the public generally but that can still affect the individual taxpayer in ways that are not common to the public. See *Helena Parents*, 277 Mont. at 371-74, 922 P.2d at 1142-44 (citing *Warth v. Seldin* (1975), 422 U.S. 490, 498, 95 S.Ct. 2197, 2205, 45 L.Ed.2d 343; *Flast v. Cohen* (1968), 392 U.S. 83, 99-100, 88 S.Ct. 1942, 1952, 20 L.Ed.2d 947; *Virginia v. American Booksellers Ass'n* (1988), 484 U.S. 383, 392-93, 108 S.Ct. 636, 642-43, 98 L.Ed.2d 782; *United States v. SCRAP* (1973), 412 U.S. 669, 93 S.Ct. 2405, 37 L.Ed.2d 254; *Sierra Club v. Morton* (1972), 405 U.S. 727, 734, 92 S.Ct. 1361, 1366, 31 L.Ed.2d 636).

¶ 8 The case at bar--involving constitutional issues related to abortion and privacy--presents a standing question of first impression in Montana. It is one which does not fit precisely within the parameters of the broadened two-part rule set out above. Specifically, the standing question can be phrased as: Where governmental regulation directed at health care providers impacts the constitutional rights of women patients, may a health care provider litigate the infringement of these rights on behalf of the women or must the women aggrieved assert their own rights?

9 Finding no relevant authority in Montana on this question we again turn, as we did in *Helena Parents*, to federal case law. The federal courts have thoroughly addressed and resolved whether the special relationship between a physician and patient afford the former standing to litigate the constitutional rights of the latter. See *Singleton v. Wuliff* (1976), 428 U.S. 106, 117-18, 96 S.Ct. 2868, 2875-76, 49 L.Ed.2d 826 (concluding that based on the "closeness of the relationship," physicians have standing to maintain, on behalf of their women patients, a suit challenging the constitutionality of certain Missouri abortion laws). See also *Cruzan v. Director, Missouri Dept. of Health* (1990), 497 U.S. 261, 340 n. 12, 110 S.Ct. 2841, 2884 n. 12, 111 L.Ed.2d 224 n. 12 (Stevens, J., dissenting) (stating that the United States Supreme Court has "recognized that the special relationship between patient and physician will often be encompassed within the domain of private life protected by the Due Process Clause," and citing *Griswold v. Connecticut* (1965), 381 U.S. 479, 481, 85 S.Ct. 1678, 1679, 14 L.Ed.2d 510, and *Roe v. Wade* (1973), 410 U.S. 113, 152-53, 93 S.Ct. 705, 726-27, 35 L.Ed.2d 147). See also *Planned Parenthood of Central Missouri v. Danforth* (1976), 428 U.S. 52, 59, 96 S.Ct. 2831, 2836, 49 L.Ed.2d 788 (noting that once the lower court deemed physicians had standing to bring suit on behalf of patients, it was "unnecessary to determine whether Planned Parenthood also had standing").

¶ 10 It is especially noteworthy that the federal courts have not refrained from according to physicians, threatened with the personal risk of prosecution, standing to challenge abortion restrictions by asserting the rights of their patients. The holding and analysis in *Singleton* unequivocally established that right three years after the Court decided *Roe v. Wade*. Citing prior case law where physicians had been allowed to assert the rights of their patients, the *Singleton* Court stated:

A woman cannot safely secure an abortion without the aid of a physician, and an impecunious woman cannot easily secure an abortion without the physician's being paid by the State. The woman's exercise of her right to an abortion, whatever its dimension, is therefore necessarily at stake here. Moreover, the constitutionally protected abortion decision is one in which the physician is intimately involved. See *Roe v. Wade*, 410 U.S. at 153-156, 93 S.Ct. at 726-728. Aside from the woman herself, therefore, the physician is uniquely qualified to litigate the constitutionality of the State's interference with, or discrimination against, that decision.

**370 ¶** ... For these reasons, we conclude that it generally is appropriate to allow a physician to assert the rights of women patients as against governmental interference with the abortion decision.... *Singleton*, 428 U.S. at 117-18, 96 S.Ct. at 2875-76.

¶ 11 Even the concurring-dissenting justices in *Singleton* (who disagreed with part of the Supreme Court's decision on the facts of the case) nevertheless conceded the correctness of the Court's analysis and holding in situations where the "State directly interdicted the normal functioning of the physician-patient relationship by criminalizing certain procedures." *Singleton*, 428 U.S. at 128, 96 S.Ct. at 2881 (Powell, J., concurring and dissenting).
¶ 12 That is, of course, precisely the situation in the case sub judice. The statutes challenged by the health care providers here directly interdict the normal functioning of the physician-patient relationship by criminalizing certain procedures.

¶ 13 Accordingly, on the basis of the foregoing and in the context of this case, we resolve the standing issue by adopting the approach of the federal courts. We hold that the Plaintiff health care providers have standing to assert on behalf of their women patients the individual privacy rights under Montana's Constitution of such women to obtain a pre-viability abortion from a health care provider of their choosing.

Scope of Opinion

¶ 14 Having thus resolved the standing issue, we also conclude that in the context of this case, Article II, Section 10 of the Montana Constitution broadly guarantees each individual the right to make medical judgments affecting her or his bodily integrity and health in partnership with a chosen health care provider free from government interference. More narrowly, we conclude that Article II, Section 10, protects a woman's right of procreative autonomy--i.e., here, the right to seek and to obtain a specific lawful medical procedure, a pre-viability abortion, from a health care provider of her choice.

¶ 15 Importantly, this case requires that we decide who should set the standards for reasonable medical practice and procedure in this State. As in the case at bar, should legislators determine these standards based upon prevailing political ideology, personal values and beliefs, and under pressure from a vocal and powerful constituency? Or, should these standards be set by the medical community in the exercise of its collective professional expertise and judgment, acting through the state's medical examining and licensing authorities, and after taking into consideration the education, training, experience and skills of the health care provider and the patient's health interests? [FN2]


¶ 16 Finally, we must decide whether, in the case before us, the government has demonstrated a compelling state interest for infringing women's right of procreative autonomy guaranteed under Article II, Section 10 of the Montana Constitution. In this regard, we conclude that it has not.

Factual and Procedural Background

¶ 17 To place the challenged legislation in proper perspective, we review the history and evolution of the related statutory provisions. In response to the United States Supreme Court's decision in Roe v. Wade, the Montana Legislature enacted the Montana Abortion Control Act (the Act), Title 50, Chapter 20 of the Montana Code Annotated. Included in that legislation were the following provisions:

Control of practice of abortion. (1) No abortion may be performed within the state of Montana: (a) except by a licensed physician; (b) after the first 3 months of pregnancy, except in a hospital licensed by the department;...

**371 (4) No physician, facility, or other person or agency shall engage in solicitation, advertising, or other form of communication having the purpose of inviting, inducing, or attracting any person to come to such physician, facility, or other person or agency to have an abortion or to purchase abortificients.


¶ 18 In December 1992, Arlette Randash (Randash), Executive Director of the Montana Right to Life Association, and Charles Lorentzen (Lorentzen), President of Flathead Pro-Life, began writing *369 letters to various individuals in state and local government arguing that criminal charges should be brought against Dr. Armstrong and P.A. Cahill. In a December 7, 1992 letter to then Attorney General Marc Racicot, Randash asked Racicot to investigate the performance of abortions by a physician assistant working at Dr. Armstrong's office and for Racicot to inform Randash of his findings. Randash alleged that the abortions were being performed in violation of § 50-20-109, MCA.

¶ 19 In March 1993, Lorentzen sent similar letters regarding Dr. Armstrong to Racicot, who by then was Governor of Montana, to Flathead County Attorney Tom Esch, and to Eleanor Parker, Montana Department of Health and Environmental Sciences counsel. Lorentzen alleged that Dr. Armstrong had violated the Act, specifically § § 50-20-109(1)(a), (b) and (4), MCA. Parker referred the letter to Attorney General Joe Mazurek who referred the matter to Esch. On April 9, 1993, Esch asked Detective Ron Fredenberg of the Kalispell Police Department to investigate the performance of abortions at Dr. Armstrong's office by a person other than a licensed physician and the performance of...
second-trimester abortions outside of a hospital.

¶ 20 Dr. Armstrong and P.A. Cahill, the only physician assistant in the State performing abortions, challenged various provisions of the Act in federal court. Subsequently, the State stipulated to a permanent injunction prohibiting enforcement of Montana's requirement that abortions be performed only by licensed physicians as well as a permanent injunction against the second-trimester hospitalization requirement and the ban on advertising.

¶ 21 In 1995, Representative Susan Smith (Smith) of Kalispell, sponsored House Bill 442 to amend § 37-20-103, MCA (a portion of the Montana Code regulating physician assistants-certified), and § 50-20-109, MCA, to specifically exclude physician assistants-certified from performing abortions. Ch. 321, L.1995. Thus, as noted by District Judge Sherlock, these amendments trace their genesis to the complaints and demands addressed to county and state officials by certain anti-abortion groups operating in the Flathead Valley of northwestern Montana.

¶ 22 Smith contended in hearings before the House Committee on Human Services and Aging, and the Senate Committee on Public Health, Welfare & Safety, that HB 442 was intended to protect women who are seeking abortions from possible complications and that the legislation was a women's health and safety issue. However, at the hearings, Smith and other proponents of the legislation failed to relate *370 any complications or problems encountered by patients of P.A. Cahill during the more than twenty years that P.A. Cahill has been performing abortions.

¶ 23 Furthermore, those testifying in support of HB 442 during the February 10, 1995 hearing before the House Committee on Human Services and Aging, and the March 10, 1995 hearing before the Senate Committee on Public Health, Welfare and Safety, failed to give any medical justification for excluding physician assistants-certified from performing abortions. Moreover, none of the proponents of HB 442 testifying before the House Committee and only one of the proponents of HB 442 testifying before the Senate Committee was a licensed physician. Instead, those testifying in favor of HB 442 included representatives of the Montana Right to Life Association, the Montana Catholic Conference, and Eagle Forum, as well as the Executive Director of the Montana Christian Coalition.

¶ 24 Opponents of HB 442 testified that, since there were no medical reasons why physician assistants-certified could not perform **372 abortions, HB 442 was just another obstacle to affordable health care for women. Those testifying against HB 442 included both current and former members of the Montana Board of Medical Examiners, the Executive Director of the American Civil Liberties Union of Montana, and the President of the Montana Academy of Physician Assistants, as well as representatives of the Montana Women's Lobby, the Montana Business and Professional Women's Association, the Center for Reproductive Law and Policy, and the National Abortion and Reproductive Rights Action League.

¶ 25 HB 442 was passed by the Montana Legislature and signed into law by Governor Racicot on April 3, 1995. Through the passage of this bill, § 37- 20-103, MCA, was amended to include the following sentence: "A physician assistant-certified may not perform an abortion." And, § 50-20-109, MCA, was amended to include a new subsection (5) that provides: "The utilization plan of a physician assistant-certified may not provide for performing abortions." In addition, such conduct was criminalized as a felony. Section 50-20-109(6), MCA. Passage of HB 442 also effectively re-enacted the provisions requiring second trimester abortions to be performed in a hospital and banning advertising.

¶ 26 Dr. Armstrong and P.A. Cahill, along with various other abortion providers, responded to the amendment of § 37-20-103, MCA, and § 50-20-109, MCA, by filing suit in federal court to prevent enforcement of the amended statutes regarding physician assistants. They also sought to prevent the enforcement of the second trimester *371 hospitalization requirement and the ban on advertising which were re-enacted by the amendment of the statute. The trial court enjoined enforcement of the re-enacted abortion restrictions, but declined to grant a preliminary injunction against enforcement of the ban on Dr. Armstrong's utilization of P.A. Cahill to perform abortions. Armstrong v. Mazurek (D.Mont.1995), 906 F Supp. 561.

¶ 27 On appeal, the Ninth Circuit vacated the District Court's denial of a preliminary injunction against enforcement of the statutes restricting the performance of abortions to licensed physicians and remanded the case to the District Court. Armstrong v. Mazurek (9th Cir.1996), 94 F.3d 566. On November 5, 1996, the State consented to an injunction against enforcement of the Act while the
State sought review by the United States Supreme Court. The Supreme Court, by a 6-3 vote, determined that Plaintiffs failed to establish the likelihood of prevailing on the merits of their claim that the statutory provisions violated due process by imposing an undue burden on a woman's right to choose to terminate a pregnancy prior to the viability of the fetus, and thus, Plaintiffs were not entitled to preliminary injunctive relief. Mazurek v. Armstrong (1997), 520 U.S. 968, 117 S.Ct. 1865, 138 L.Ed.2d 162.

¶ 28 On October 1, 1997, following the Supreme Court's ruling, Respondents filed the instant case in the District Court for the First Judicial District, Lewis and Clark County, contending that HB 442 violated Montana's constitutional provisions regarding privacy, due process, and equal protection of the laws. On November 25, 1997, the District Court granted Plaintiffs' motion for a preliminary injunction, but limited the scope of the injunction to Dr. Armstrong and P.A. Cahill. The District Court found that the Act affects a woman's constitutional right to obtain a first trimester abortion and that the State had advanced no compelling interest to justify prohibiting P.A. Cahill from performing abortions as she has safely done for the past twenty years. The State appeals the court's order granting Plaintiffs' motion for a preliminary injunction.

Discussion

I.

¶ 29 Article II, Section 10 of the Montana Constitution provides:

Right of privacy. The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest.

¶ 30 Modern legal notions of the right of privacy trace their roots to the political theory of English philosopher John Locke. Locke's concept*372 of "liberty" was prevalent in colonial America and significantly influenced **373 the framers of this country's foundation documents, including the United States Constitution. Among other things, this philosophy holds that the laws of nature require that each individual has an inherent property interest in his own person and has the capacity for and the right of rational self-determination which must be promoted and protected by civil society and political institutions. See Larry M. Elison and Dennis NettikSimmons, Right of Privacy, 48 Mont. L.Rev. 1, 17-19 (1987) (hereafter, Elison); Jeffrey S. Koehlinger, Substantive Due Process Analysis and the Lockean Liberal Tradition: Rethinking the Modern Privacy Cases, 65 Ind. L.J. 723 (1990).

¶ 31 John Stuart Mill recognized this fundamental right of self-determination and personal autonomy as both a limitation on the power of the government and as principle of preeminent deference to the individual. He stated:

[T]he only purpose for which power can be rightfully exercised over any member of a civilised [sic] community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because, it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right.


¶ 32 Despite prior judicial recognition of this general "liberty interest" or right of privacy by both the United States Supreme Court and this Court [FN3], the delegates to Montana's 1972 Constitutional Convention*373 viewed the textual inclusion of this right in Montana's new constitution as being necessary for the protection of the individual in "an increasingly complex society ... [in which] our area of privacy has decreased, decreased, decreased." This "right to be let alone ... the most important right of them all," as Delegate Campbell put it, "produces ... a semipermeable wall of separation between individual and state" in much the same fashion that a constitutional wall [FN4] separates church and state. Montana Constitutional Convention, Verbatim Transcript, March 7, 1972, p. 1681.

FN4. In his remarks to the Constitutional Convention, Delegate Campbell referred to this constitutional wall of separation as being "absolute". Notwithstanding, neither the United States Supreme Court nor this Court have interpreted constitutional church/state separation as being absolute. Both Courts have recognized that some governmental impacts on religious freedoms is constitutionally permitted. See St. John's Lutheran Church v. State Comp. Ins. Fund (1992), 252 Mont. 516, 523-24, 830 P.2d 1271, 1276-77 (citing Cantwell v. State of Connecticut (1940), 310 U.S. 296, 60 S.Ct. 900, 84 L.Ed. 1213, and United States v. Lee (1982), 455 U.S. 252, 102 S.Ct. 1051, 71 L.Ed.2d 127).

¶ 33 Furthermore, it is clear from their debates that the delegates intended this right of privacy to be expansive--that it should encompass more than traditional search and seizure. The right of privacy should also address information gathering and protect citizens from illegal private action and from legislation and governmental practices that interfere with the autonomy of each individual to make decisions in matters generally considered private. Elison, at 11-13.

[4][5] ¶ 34 With this background, and as correctly noted by Judge Sherlock, Montana adheres to one of the most stringent protections of its citizens' right to privacy in the United States--exceeding even that provided **374 by the federal constitution. State v. Burns (1992), 253 Mont. 37, 40, 830 P.2d 1318, 1320 (citing Montana Human Rights Division v. City of Billings (1982), 199 Mont. 434, 439, 649 P.2d 1283, 1286). Indeed, since the right of privacy is explicit in the Declaration of Rights of Montana's Constitution, it is a fundamental right. Gryczan v. State (1997), 283 Mont. 433, 449, 942 P.2d 112, 122. It is, perhaps, one of the most important rights guaranteed to the citizens of this State, and its separate textual protection in our Constitution reflects Montanans' historical abhorrence and distrust of excessive governmental interference in their personal lives.

Gryczan, 283 Mont. at 455, 942 P.2d at 125. For this reason, legislation infringing the exercise of the right of privacy must be reviewed *374 under a strict-scrutiny analysis--i.e., the legislation must be justified by a compelling state interest and must be narrowly tailored to effectuate only that compelling interest. Gryczan, 283 Mont. at 449, 942 P.2d at 122 (citing State v. Siegal (1997), 281 Mont. 250, 263, 934 P.2d 176, 184, overruled in part by State v. Kaneff (1998), 291 Mont. 474, 970 P.2d 556).

II.

[6] ¶ 35 As noted, Article II, Section 10 of the Montana Constitution was intended by the delegates to protect citizens from illegal private action and from legislation and governmental practices that interfere with the autonomy of each individual to make decisions in matters generally considered private. However, it was not until our decision in Gryczan that this Court directly addressed and judicially recognized this "personal autonomy" component of Montanans' fundamental constitutional right of individual privacy. Gryczan, 283 Mont. at 450-51, 942 P.2d at 123. See also Elison, at 13 n. 83; Scott A. Fisk, The Last Best Place to Die: Physician-Assisted Suicide and Montana's Constitutional Right to Personal Autonomy Privacy, 59 Mont. L. Rev. 301, 323-25 (1998) (hereafter, Fisk). In Gryczan, we held that the personal autonomy component of the right of individual privacy includes the right of consenting adults to engage in private, same-gender, non-commercial sexual conduct free from governmental interference, intrusion and condemnation. Gryczan, 283 Mont. at 455-56, 942 P.2d at 126. Beyond that, however, we made no attempt to define personal autonomy as a component of the right of individual privacy or to articulate its scope.

¶ 36 While some suggest that this was an oversight--see Fisk, at 326--neither did the delegates to Montana's Constitutional Convention attempt to circumscribe the right to privacy. Rather the Bill of Rights Committee proposed "a broad provision ... to permit flexibility to the courts in resolving the tensions between public interest and privacy." Montana Constitutional Convention, Committee Proposals, February 22, 1972, pp. 632-33. As Delegate Campbell noted: We had much discussion before [the Bill of Rights Committee], and why not try to define the right, to put in specific examples. But it was our feeling that once you do that, you are running a risk that you may eliminate other areas in the future which may be developed by the court.

Montana Constitutional Convention, Verbatim Transcript, March 9, 1972, p. 1851. In truth, that the Convention delegates deliberately *375 drafted a broad and undefined right of "individual" [FN5] privacy was more a testament to and culmination of Montanans' continuous and zealous protection of a core sphere of personal autonomy and dignity than it was an attempt to create a greater right than that which already existed by historical precedent. See William C. Rava, Toward a Historical Understanding of Montana's Privacy Provisions, 61 Alb. L.Rev. 1681, 1716-17 (1998).


¶ 37 Yet, defining personal autonomy has and continues to challenge courts, philosophers and authors. For example, the United States Supreme Court has stated that the right involves "intimate and personal choices" that concern "the right to define one's own concept of existence, of meaning, **375 of the universe, and of the mystery of human life," Planned Parenthood v. Casey (1992), 505 U.S. 833, 851, 112 S.Ct. 2791, 2807, 120 L.Ed.2d 674. It may also be that, as Fisk suggests, personal autonomy encompasses [t]he complex human capacities that ... include language, self-consciousness, memory, logical relations, empirical reasoning about beliefs and their validity (human intelligence), and the capacity to use normative principles ... [and] ... rational choice, to decide which among several ends may be most effectively and coherently realized. Fisk, at 327 (quoting David A.J. Richards, Sex, Drugs, Death and the Law 8 (1982)). Or, more simply, as John Stuart Mill stated: "Over himself, over his own body and mind, the individual is sovereign." Mill, On Liberty (quoted in Thor v. Superior Court (1993), 5 Cal.4th 725, 21 Cal.Rptr.2d 357, 855 P.2d 375, 380).

[7] ¶ 38 Attempts to define this right notwithstanding, we conclude that, while it may not be absolute, no final boundaries can be drawn around the personal autonomy component of the right of individual privacy. It is, at one and the same time, as narrow as is necessary to protect against a specific unlawful infringement of individual dignity and personal autonomy by the government--as in Gryczan--and as broad as are the State's ever innovative attempts to dictate in matters of conscience, to define individual values, and to condemn those found to be socially repugnant or politically unpopular.

*376 III.

[8][9] ¶ 39 And that brings us to the matter at bar: broadly, the right of each individual to make medical judgments affecting her or his bodily integrity and health in partnership with a chosen health care provider free from the interference of the government; and, more narrowly, a woman's right to seek and obtain pre-viability abortion services. The former is protected under the personal autonomy component of the fundamental right of individual privacy set out in Article II, Section 10 of the Montana Constitution. The latter--procreative autonomy--is a protected form of personal autonomy. Since the primary focus of this case is the latter, we begin with that.

[10] ¶ 40 There is no doubt that a woman's right to choose to have an abortion before fetal viability and to obtain it without "undue interference" or "undue burden" from the state is protected under the federal constitution. Planned Parenthood, 505 U.S. at 846, 112 S.Ct. at 2804. This federal constitutional right is grounded in privacy and is protected under the Due Process Clause of the Fourteenth Amendment. Roe, 410 U.S. at 153, 93 S.Ct. at 727; Planned Parenthood, 505 U.S. at 846, 112 S.Ct. at 2804.

[11][12] ¶ 41 Notwithstanding, and independently of the federal constitution, where the right of individual privacy is implicated, Montana's Constitution affords significantly broader protection than does the federal constitution. Gryczan, 283 Mont. at 448, 942 P.2d at 121 (citation omitted). Article II, Section 10, requires more than that the State simply not impose an undue burden on a person's exercise of his or her right of individual privacy. Rather, under Montana's Constitution, the government must demonstrate a "compelling state interest" for infringing this right. [FN6] Gryczan, 283 Mont. at 449, 942 P.2d at 122 (citation omitted).

FN6. We have not, heretofore, specifically defined what makes a state interest "compelling," rather, leaving that determination to be made case by case. Nonetheless, we agree with the United States Supreme Court's test in the First Amendment free exercise cases, that to demonstrate that its interest justifying infringement of a fundamental constitutional right is "compelling" the state must show, at a minimum, some interest "of the highest
order and ... not otherwise served," see *Wisconsin v. Yoder* (1972), 406 U.S. 205, 215, 92 S.Ct. 1526, 1533, 32 L.Ed.2d 15, or "the gravest abuse[,] endangering [a] paramount [government] interest [ ]." *Thomas v. Collins* (1945), 323 U.S. 516, 530, 65 S.Ct. 315, 323, 89 L.Ed. 430. See also *Miller v. Catholic Diocese of Great Falls* (1986), 224 Mont. 113, 116-17, 728 P.2d 794, 796 (citing *Yoder*). Some inking of the Constitutional Convention's view of how serious a situation must exist before the government has a "compelling" interest for infringing the right of individual privacy can be gleaned from delegate comment of electronic surveillance. There, Delegate Dahood noted that, if it should ever be allowed at all, "electronic surveillance shall be justified only in matters involving national security, perhaps in matters involving certain heinous federal crimes where the situation is such that in those instances we must risk the right of individual privacy because there is a greater purpose to be served." Montana Constitutional Convention, Verbatim Transcript, March 7, 1972, p. 1687.

**376 [13]** 42 Judge Sherlock determined that "if the right to privacy includes anything, it includes the decision of a woman whether or not to beget *377 or bear a child ... [and it] encompasses a woman's choice of whether or not to end her pregnancy." The court was correct in this statement of the law as derived from federal authorities. See *Eisenstadt v. Baird* (1972), 405 U.S. 438, 453, 92 S.Ct. 1029, 1038, 31 L.Ed.2d 349; *Roe*, 410 U.S. at 153, 93 S.Ct. at 727. Facially, then, procreative autonomy being grounded in the right of privacy, there is no reason why this right would not also be encompassed within the broader personal autonomy protections afforded by the fundamental right of individual privacy guaranteed by Article II, Section 10 of the Montana Constitution.

[14] 43 The State in this case disagrees, however. Rather, it contends that Montana's Constitution does not protect women's right to obtain a pre-viability abortion and that this right is subject to legislative determination and regulation within the parameters of the weaker protections afforded by the federal constitution and federal law. The State argues that Article II, Section 10, excepts a woman's choice to obtain a pre-viability abortion because of the Constitutional Convention's rejection of Delegate Kelleher's attempt to confer constitutionally protected status on a fetus at the time of conception. The government is wrong.

¶ 44 Significantly, the Convention determined not to deal with abortion in the Bill [Declaration] of Rights "at this time" and rather chose to leave the matter to the legislature because of the historical debate as to "when a person becomes a person." See comments of Delegate Dahood, Montana Constitutional Convention, Verbatim Transcript, March 7, 1972, p. 1640. *Roe*, handed down a year after the Convention, resolved this debate from the legal standpoint, concluding that a fetus does not enjoy a constitutionally protected status--i.e., that a fetus is not a constitutional person--until "viability" (at about 26 weeks or the third trimester). See *Roe*, 410 U.S. at 160, 162-65, 93 S.Ct. at 730-33; Ronald Dworkin, *Freedom's Law: The Moral Reading of the American Constitution* 87-90 (1996) (hereafter, Dworkin, *Freedom*).

*378 ¶ 45 Importantly, there is nothing in the Constitutional Convention debates which would logically lead to the conclusion that Article II, Section 10, does not protect, generally, the autonomy of the individual to make personal medical decisions and to seek medical care in partnership with a chosen health care provider free of government interference. Nor is there any reason to conclude, in light of *Roe* and post-*Roe* cases, that a woman's right to obtain a pre-viability abortion--part and parcel of her right of personal/procreative autonomy--likewise would not be encompassed within the protection of Montana's constitutional right of individual privacy. In fact, given the delegates' overriding concern that government not be allowed to interfere in matters generally considered private, and given the delegates' specific determination to adopt a broad and undefined right of individual privacy grounded in Montana's historical tradition of protecting personal autonomy and dignity, the opposite conclusion must be reached.

¶ 46 This determination is further supported by the Bill of Rights Committee's favorable reference to *Griswold v. Connecticut*, underlining its determination that the judicially-recognized right of privacy be elevated to explicit constitutional status. See Montana Constitutional Convention, Committee Proposals, February 22, 1972, p. 632. *Griswold* acknowledged the privacy interest inherent in contraception and procreation. *Griswold*, 381 U.S. at 485-86, 85 S.Ct. at 1682. Moreover, *Griswold* has been recognized to protect both "the individual interest in avoiding [accumulation and] disclosure of

¶ 47 Similarly, in the floor debates, Delegate Campbell, emphasizing Montana's historical commitment to the right of privacy and arguing for the core "right to be let alone," cited *Griswold*. [FN7] These references to **379 *Griswold* in the proceedings of the Constitutional Convention are important because

FN7. Delegate Campbell also referred to the 1890 law review article on privacy authored by Samuel Warren and Louis Brandeis (*The Right to Privacy*, 4 Harv. L. Rev. 193, 195, 205 (1890)), which asserted that the right of privacy encompasses "[t]houghts, emotions, and sensations" and the principle "of an inviolate personality"--concepts which deeply influenced the later development of American privacy jurisprudence. See Montana Constitutional Convention, *Verbatim Transcript*, March 9, 1972, p. 1851; Elison, at 2-5.

*Griswold* and [ ] other [federal] privacy decisions can be justified only on the presumption that decisions affecting marriage and childbirth are so intimate and personal that people must in principle be allowed to make these decisions for themselves, consulting their own preferences and convictions, rather than having society impose its collective decision on them.

Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, And Individual Freedom* 106 (First Vintage Books ed.1994) (hereafter, Dworkin, *Life's Dominion*). Moreover, [t]he Supreme Court, in denying the state the specific power to make contraception criminal, presupposed the more general principle of procreative autonomy.... The law's integrity demands that the principles necessary to support an authoritative set of judicial decisions must be accepted in other contexts as well. It might seem an appealing political compromise to apply the principle of procreative autonomy to contraception, which almost no one now thinks states can forbid, but not to abortion, which powerful constituencies violently oppose. But the point of integrity--the point of the law itself--is exactly to rule out political compromises of that kind. Dworkin, *Life's Dominion*, at 158.

¶ 48 Accordingly, given Montana's broad, yet undefined, concept of individual privacy--historically predating even the 1972 Constitution; given the Constitutional Convention's unmistakable intent to textualize this tradition by explicitly protecting citizens from legislation and governmental practices that interfere with the autonomy of each individual to make decisions in matters generally considered private; given the Convention's reliance on *Griswold*; and given jurisprudential recognition, following the close of the Constitutional Convention, of a woman's right to seek and obtain a pre-viability abortion, it is clear that the procreative autonomy component of personal autonomy is protected by Montana's constitutional right of individual privacy found at Article II, Section 10.

[15][16] ¶ 49 Implicit in this right of procreative autonomy is a woman's moral right and moral responsibility to decide, up to the point of fetal viability, what her pregnancy demands of her in the context of her individual values, her beliefs as to the sanctity of life, and her personal situation. Moreover, the State has no more compelling interest or constitutional justification for interfering with the exercise of this right **380 if the woman chooses to terminate her pre-viability pregnancy than it would if she chose to carry the fetus to term. Recognition of this point is important--especially for those who reject abortion. For if the State has the power to infringe the right of procreative autonomy in favor of birth, then, necessarily, it also has the power to require abortion under some circumstances. If one accepts the former, then imposition of the latter is no more remote than a change in prevailing political ideology.

¶ 50 And, if the reader finds this farfetched or shocking, consider that in 1927 the United States Supreme Court ruled that eugenics by involuntary sterilization of the mentally retarded was constitutionally permissible. According to that Court, "[i]t is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society **378 can prevent those who are manifestly unfit from continuing their kind." *Buck v. Bell* (1927), 274 U.S. 200, 207, 47 S.Ct. 584, 585, 71 L.Ed. 1000. Or, consider the United States Congressional Office of Technology Assessment's 1988 discussion of "Social and Ethical
Considerations" raised by the Human Genome Project:

Human mating that proceeds without the use of genetic data about the risks of transmitting diseases will produce greater mortality and medical costs than if carriers of potentially deleterious genes are alerted to their status and encouraged to mate with noncarriers or to use artificial insemination or other reproductive strategies. See George J. Annas, Standard of Care: The Law of American Bioethics 156 (1993) (quoting U.S. Congress, Office of Technology Assessment, Mapping Our Genes: Genome Projects, How Big, How Fast? 84 (U.S. Govt. Print Office 1988)).

¶ 51 Unless fundamental constitutional rights--procreative autonomy being the present example--are grounded in something more substantial than the prevailing political winds, Huxley's Brave New World or Orwell's 1984 will always be as close as the next election. Fortunately, as demonstrated above, the roots of Montana's constitutional right of procreative autonomy go much deeper and are firmly embedded in the right of individual privacy guaranteed under Article II, Section 10 of the Montana Constitution.

IV.

¶ 52 Similarly, in the broader context of one's right to choose or refuse medical treatment, we must likewise conclude that these sorts of *381 decisions are protected under the personal autonomy component of the individual privacy guarantees of Montana's Constitution. And properly so.

[17] ¶ 53 Few matters more directly implicate personal autonomy and individual privacy than medical judgments affecting one's bodily integrity and health. Joel Feinberg, a philosophy professor at the University of Arizona, describes the interrelationship between privacy and personal or "bodily" autonomy as follows:

After all, we speak of "bodily autonomy," and acknowledge its violation in cases of assault, battery, rape, and so on. But surely our total autonomy includes more than simply our bodily "territory," and even in respect to it, more is involved than simple immunity to uninvited contacts and invasions. Not only is my bodily autonomy violated by a surgical operation ("invasion") imposed on me against my will; it is also violated in some circumstances by the withholding of the physical treatment I request (when due allowance has been made for the personal autonomy of the parties of whom the request is made). For to say that I am sovereign over my bodily territory is to say that I, and I alone, decide (so long as I am capable of deciding) what goes on there. My authority is a discretionary competence, an authority to choose and make decisions. 3 Joel Feinberg, Harm to Self 53 (1986). See also Fisk, at 326-27.

¶ 54 Indeed, medical treatment decisions are, to an extraordinary degree, intrinsically personal. It is the individual making the decision, and no one else, who lives with the pain and disease. It is the individual making the decision, and no one else, who must undergo or forego the treatment. And it is the individual making the decision, and no one else, who, if he or she survives, must live with the results of that decision. One's health is a uniquely personal possession. The decision of how to treat that possession is of a no less personal nature.

... The decision can either produce or eliminate physical, psychological, and emotional ruin. It can destroy one's economic stability. It is, for some, the difference between a life of pain and a life of pleasure. It is, for others, the difference between life and death.

Andrews v. Ballard (D.C.S.D.Tex.1980), 498 F.Supp. 1038, 1047 (holding that the decision to obtain or reject medical treatment is encompassed by the right of privacy and that, absent evidence showing that they were narrowly drawn to achieve a compelling state interest, Texas regulations requiring acupuncturists to be licensed physicians *382 imposed **379 a burden on and significantly interfered with the patient's decision to obtain acupuncture treatment and were, therefore, unconstitutional). [FN8]

FN8. Andrews collects the cases from various federal and state jurisdictions which have directly addressed the question of whether the right of privacy encompasses the decision to obtain or reject medical treatment. The "clear trend of modern authority," answers this question in the affirmative. Andrews, 498 F.Supp. at 1048-51. Since Andrews was handed down other jurisdictions have embraced this view. See American Academy of Pediatrics v. Lungren (1997), 16 Cal.4th 307, 66 Cal.Rptr.2d 210, 940 P.2d 797 (statute requiring pregnant minors to secure parental consent or judicial authorization before obtaining an abortion violated minor's privacy right); Singletary v. Costello (Fla.Dist.Ct.App.1996), 665 So.2d

1099 (prison inmate on hunger strike had privacy right to refuse medical intervention); *Women of the State of Minnesota v. Gomez* (Minn.1995), 542 N.W.2d 17 (statutes that permitted use of public funds for childbirht-related medical services, but prohibited similar use of public funds for medical services related to therapeutic abortions, impermissibly infringed on woman's right of privacy); *In re Daniel Joseph Fiori* (1995), 438 Pa.Super. 610, 652 A.2d 1350 (privacy right guarantees the right to make important personal decisions including termination of life-sustaining treatment); *Louisiana v. Perry* (La.1992), 610 So.2d 746 (state may not violate incompetent death row prisoner's privacy right by medicating prisoner against his will with antipsychotic drugs in order to carry out death sentence while prisoner is under the influence of such drugs); *Norwood Hospital v. Munoz* (1991), 409 Mass. 116, 564 N.E.2d 1017 (patient had privacy right to refuse blood transfusion); *In re the Guardianship of Estelle M. Browning* (Fla.1990), 568 So.2d 4 (surrogate or proxy may exercise privacy right for incompetent patient and terminate patient's artificial life support as long as patient, while competent, had expressed wish to do so); *In re T.W.* (Fla.1989), 551 So.2d 1186 (privacy right to terminate pregnancy extends to minors); McConnell v. Beverly Enterprises-Conn., Inc. (1989), 209 Conn. 692, 553 A.2d 596 (family of terminally ill patient could exercise patient's privacy right to removal of artificial nutrition and hydration); *Gray v. Romeo* (D.R.I.1988), 697 F.Supp. 580 (patient's privacy right encompases the right to refuse life-sustaining medical treatment); Ragsdale v. Turnock (7th Cir.1988), 841 F.2d 1358 (statutes requiring physicians to perform "elective abortions" only in designated facilities impacted woman's privacy right to an abortion); *United States v. Charters* (4th Cir.1987), 829 F.2d 479 (medically competent defendant has privacy right to refuse antipsychotic medication); *Rasmussen v. Fleming* (1987), 154 Ariz. 207, 741 P.2d 674 (public fiduciary as guardian of nursing home patient in chronic vegetative state had authority to exercise patient's privacy right to refuse medical treatment with regard to "do not resuscitate" and "do not hospitalize" notations placed on patient's medical chart); *Foody v. Manchester Memorial Hospital* (1984), 40 Conn.Supp. 127, 482 A.2d 713 (family of semicomatose patient could exercise patient's privacy right to discontinue use of all artificial devises intended to continue patient's respiration and pulse); *In the Matter of Welfare of Bertha Colyer* (1983), 99 Wash.2d 114, 660 P.2d 738 ("an adult who is incurably and terminally ill has a constitutional right of privacy that encompases the right to refuse treatment that serves only to prolong the dying process"); *Severns v. Wilmington Medical Center, Inc.* (Del.Ch.1980), 425 A.2d 156 (guardian of comatose patient may assert patient's privacy right to discontinue life support).

¶ 55 Recognition of these inherent rights to make medical judgments affecting one's bodily integrity and health and the right to choose and to refuse medical treatment are certainly not creatures of recent invention, however. Rather, like America's historical legal tradition acknowledging the fundamental common law right of self-determination, acceptance of the right to make personal medical decisions as inherent in personal autonomy is a long-standing and an integral part of this country's jurisprudence.

¶ 56 Over a century ago, the Supreme Court observed:

No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. *Union Pacific Railway Co. v. Botsford* (1891), 141 U.S. 250, 251, 11 S.Ct. 1000, 1001, 35 L.Ed. 734. Eighty-five years ago, Justice Cardozo noted that, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." *Schloendorf v. Society of New York Hosp.* (1914), 211 N.Y. 125, 105 N.E. 92, 93, overruled in part by Bing v. Thunig, (1957), 2 N.Y.2d 656, 163 N.Y.S.2d 3, 143 N.E.2d 3. And, more recently, the Supreme Court has reaffirmed that the right to control fundamental medical decisions is an aspect of the right of self-determination and personal autonomy that is "deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland* (1977), 431 U.S. 494, 503, 97 S.Ct. 1932, 1937, 52 L.Ed.2d 531. *See also Matter of Quinlan*...
¶ 57 In the context of "informed consent" cases, Montana, too, has recognized that each individual is the sovereign of his or her own body. *Collins v. Itoh* (1972), 160 Mont. 461, 467, 503 P.2d 36, 40 ("Each man is considered master of his own body and may request or prohibit even lifesaving surgery. The law will not allow a physician to substitute his own judgment, no matter how well founded, for that of his patient.") (citing *Natanson v. Kline* (1960), 186 Kan. 393, 350 P.2d 1093, 1104). See also Dworkin, *Freedom*, at 134 ("The law of most American states seems settled that the autonomy of a competent patient will be decisive ... and that doctors may not treat him against his will either for his sake or for the sake of some social interest in keeping him alive").

*384 V.*

¶ 58 Acknowledging these precepts of patient autonomy, however, is not to deny the obvious--that medical decisions affecting one's bodily integrity and health must often and necessarily be made in partnership with a health care provider. In those instances, the individual typically seeks out and may consent to the most risky and intimate invasions of body and psyche, largely upon her or his personal trust in the education, training, experience, advice, and professional integrity of the health care provider he or she has chosen. This truism points up the seriousness of the infringement of personal autonomy and privacy that accompanies the government usurping, through laws or regulations which dictate how and by whom a specific medical procedure is to be performed, the patient's own informed health care decisions made in partnership with his or her chosen health care provider.

[18] ¶ 59 Certainly, this right of choice in making personal health care decisions and in exercising personal autonomy is not without limits. In narrowly defined instances the state, by clear and convincing evidence, may demonstrate a compelling interest in and obligation to legislate or regulate to preserve the safety, health and welfare of a particular class of patients or the general public from a medically-acknowledged, *bona fide* health risk. Subject to this narrow qualification, however, the legislature has neither a legitimate presence nor voice in the patient/health care provider relationship superior to the patient's right of personal autonomy which protects that relationship from infringement by the state.

[19] ¶ 60 Worse, when, as in the case at bar, the legislature thrusts itself into this protected zone of individual privacy under the guise of protecting the patient's health, but, in reality, does so because of prevailing political ideology and the unrelenting pressure from individuals and organizations promoting their own beliefs and values, then the state's infringement of personal autonomy is not only constitutionally impermissible, it is, as well, intellectually and morally indefensible.

¶ 61 Long ago, this Court declared that "the State Constitution is a limitation upon the power of the legislature and not a grant of power to that body." *State v. Aronson* (1957), 132 Mont. 120, 127, 314 P.2d 849, 852 (citing *State ex rel. DuFresne v. Leslie* (1935), 100 Mont. 449, 50 P.2d 959). Just as the government has no business in the bedrooms of consenting adults, *Gryczan*, 283 Mont. at 450, 942 P.2d at 122, neither does it have any business in the treatment rooms of their health *385* care providers, except under the very narrowly defined circumstances referred to above.

[20][21] ¶ 62 Simply put, except in the face of a medically-acknowledged, *bona fide* health risk, clearly and convincingly demonstrated, the legislature has no interest, much less a compelling one, to justify its interference with an individual's fundamental privacy right to obtain a particular lawful medical procedure from a health care provider that has been determined by the medical community to be competent to provide that service and who has been licensed to do so. To this end, it also logically and necessarily follows that legal standards for medical practice and procedure cannot be based on political ideology, but, rather, must be grounded in the methods and procedures of science and in the *381* collective professional judgment, knowledge and experience of the medical community acting through the state's medical examining and licensing authorities.

VI.

¶ 63 The case at bar, unfortunately, exemplifies the gross violation of these principles. Based upon P.A. Cahill's education, training and experience, the Board of Medical Examiners, in its professional judgment, determined that, under the supervision of a licensed physician, she was competent to perform certain types of abortions and other even more risky medical procedures. In the District Court, the government failed utterly to demonstrate why this determination was wrong or that the State had a compelling interest for effectively infringing the right of procreative autonomy of women to obtain a pre-
viability abortion and their right of personal autonomy to choose P.A. Cahill, under the supervision of Dr. Armstrong, to perform this lawful medical procedure.

¶ 64 Rather, the record shows that the legislature chose to prohibit P.A. Cahill from performing abortions, yet made no attempt to prohibit her from performing other more risky medical procedures such as uncomplicated deliveries of babies [FN9], inserting IUDs, and prescribing and administering most drugs. The record also shows that the legislature chose to prohibit P.A. Cahill from executing various procedures at the direction of the doctor performing a medical abortion, yet *386 did not prohibit registered nurses or others with less training than P.A. Cahill from executing those same procedures. The record shows that P.A. Cahill has been performing abortions with the approval of the Montana Board of Medical Examiners since 1983; that she has performed approximately 3,000 abortions; that she has never been sued for malpractice or disciplined; and that Dr. Armstrong's rate of complications for patients obtaining abortions from him is the same as the rate for patients obtaining abortions from P.A. Cahill. [FN10] The record shows, and Judge Sherlock found, that "[t]here is simply no evidence to support the contention that this practice by Cahill and Armstrong in any way endangers women's health." In short, the record shows that "protecting women's health" served as a little more than a rhetorical guise for enacting the 1995 amendments to § 37-20-103, MCA, and § 50-20-109, MCA, and the record of this case demonstrate how unremitting pressure from individuals and organizations promoting their own particular values influence politicians to legislate, often via the back door, in matters of personal conscience, belief and choice and, concomitantly, infringe the zone of personal autonomy and procreative autonomy protected by the right of individual privacy. The reality of this case is that, while the legislature could not make pre-viability abortions facially unlawful, it could, and did--under the facade of "protecting women's health" and the lesser "undue burden" test of Planned Parenthood--attempt to make it as difficult, as inconvenient and as costly as possible for women to exercise their right to obtain, from the health care provider of their choice, [FN11] a specific *387 medical procedure **382 protected by the Due Process Clause of the federal constitution and, independently of the Fourteenth Amendment, protected by their greater right of individual privacy under Article II, Section 10 of the Montana Constitution. Furthermore, that the 1995 amendments to § 37-20-103, MCA, and § 50-20-109, MCA, may have been narrowly drawn is irrelevant, where, as here, there was no predicate compelling state interest justifying the amendments in the first place.

FN9. Judge Sherlock noted that P.A. Cahill can still perform deliveries of babies in her status as a physician assistant and that these deliveries have the same or greater risk than the sorts of abortion procedures she provided. Specifically, these abortions are classified as Risk Level 2 by the State Board of Medical Examiners while the higher Risk Level 3 is associated with child birth.

FN10. As noted by the District Court, this conclusion is supported by a Vermont study concluding that the rate of complications between abortions conducted by physicians and those conducted by physician assistants is no different. Freedman, Jillson, Coffin and Novick, Comparison of complication rates in first trimester abortions

[23] ¶ 65 Indeed, the history of the 1995 amendments to § 37-20-103, MCA, and § 50-20-109, MCA, and the record of this case demonstrate how unremitting pressure from individuals and organizations promoting their own particular values influence politicians to legislate, often via the back door, in matters of personal conscience, belief and choice and, concomitantly, infringe the zone of personal autonomy and procreative autonomy protected by the right of individual privacy. The reality of this case is that, while the legislature could not make pre-viability abortions facially unlawful, it could, and did--under the facade of "protecting women's health" and the lesser "undue burden" test of Planned Parenthood--attempt to make it as difficult, as inconvenient and as costly as possible for women to exercise their right to obtain, from the health care provider of their choice, [FN11] a specific *387 medical procedure **382 protected by the Due Process Clause of the federal constitution and, independently of the Fourteenth Amendment, protected by their greater right of individual privacy under Article II, Section 10 of the Montana Constitution. Furthermore, that the 1995 amendments to § 37-20-103, MCA, and § 50-20-109, MCA, may have been narrowly drawn is irrelevant, where, as here, there was no predicate compelling state interest justifying the amendments in the first place.

FN11. The insidious effect of the amendments to the statutes is even more apparent when one recognizes that they severely limit a woman's choice to obtain an intimate, female-specific medical procedure from a health care provider of her own gender. One can imagine the wailing and gnashing of male teeth if a legislature dominated by women, in the "interest of men's health," enacted a law which effectively guaranteed that vasectomies and prostate examinations would only be performed by female physicians.

¶ 66 There is simply no evidence in the record of this case that laws requiring pre-viability abortions be performed only by a physician to the exclusion of a trained, experienced and medically competent physician assistant-certified, working under the supervision of a licensed physician, are necessary to protect the life, health or safety of women in this
State. Indeed, there is overwhelming evidence to the contrary and that the 1995 amendments to § 37-20-103, MCA, and § 50-20-109, MCA, were the product of and grounded in nothing other than the divisive and vocal politics of abortion.

VII.

A. ¶ 67 That said, we close with two final observations. First, from our foregoing discussion, it should be apparent that this opinion is about the government’s infringement of certain fundamental rights of individual privacy—personal and procreative autonomy—guaranteed under Article II, Section 10 of the Montana Constitution. From this same discussion, it should be equally obvious, what this opinion is not about. For the reasons hereafter set forth, the latter needs to be underscored, nonetheless. This opinion is not a comment, pro or con, on the merits of sectarian doctrine or on the deep and sincerely held personal beliefs, values and convictions of those who either favor abortion or who oppose it on moral or religious grounds.

[24][25] ¶ 68 Unfortunately, however, it is these doctrines, values, beliefs and convictions which invariably fuel the hurricane of legal debate on this issue. And that, of course, is precisely the problem. The government can demonstrate no compelling interest for legislating on the basis of any sectarian doctrine nor may the state infringe individual liberty and personal autonomy because of majoritarian demands to safeguard some intrinsic value unrelated to the protection of the rights and interests of persons with constitutional status. The fundamental right to personal and procreative autonomy and, in the broader sense, to individual privacy, prohibits the government from dictating, approving or condemning values, beliefs and matters ultimately involving individual conscience, where opinions about the nature of such values and beliefs are seriously divided; where, at their core, such values and beliefs reflect essentially religious convictions that are fundamental to personal identity; and where the government’s decision has a greatly disparate impact on the persons whose individual beliefs and personal commitments are displaced by the State’s legislated values. See Dworkin, Life’s Dominion, at 157; Dworkin, Freedom, at 101-102.

[26][27] ¶ 69 That is not to say that matters involving religious values and individual conscience are not appropriately addressed by churches, other organizations and individuals in both sectarian and secular forums. Indeed, such expression aimed at changing individual values and convictions and at fostering respect for the intrinsic value of all life is protected by the First Amendment and, independently of the federal constitution, by Article II, Sections 5 and 7 of the Montana Constitution. However the doctrine of separation of church and state which is also embodied in the First Amendment and, independently, in Article II, Section 5, makes theology an impermissible basis on which to make law or interpret the Constitution. Religious arguments do not count as legal arguments. See Dworkin, Life’s Dominion, at 110.

[28] ¶ 70 For this reason, and without abandoning their own personal beliefs and convictions, those in government who make, execute and interpret the law and who are sworn to support, protect and defend the Constitution may not, except in violation of their oaths of office, succumb to the pressure of those who would engraft the sectarian tenets and personal values of some onto the laws which govern all.

B. ¶ 71 Our second observation concerns the manner in which the matters discussed in this opinion arise under Montana’s Constitution. In keeping with the way in which the issues were argued to and decided by the trial court, we have directed our focus in this opinion to the right of individual privacy found at Article II, Section 10. It bears noting, however, that Montana’s Constitution, and especially the Declaration of Rights, is not simply a cook book of disconnected and discrete rules written with the vitality of an automobile insurance policy. Rather, our Constitution, and in particular its Declaration of Rights, encompasses a cohesive set of principles, carefully drafted and committed to an abstract ideal of just government. It is a compact of overlapping and redundant rights and guarantees. See Dworkin, Freedom, at 110; Dworkin, Life’s Dominion, at 166. Thus, the rights of personal and procreative autonomy at issue here also find protection in more than just Article II, Section 10. Without attempting to exhaustively plumb the depths of the Constitution in this regard, several provisions of the Declaration of Rights deserve mention.

[29][30][31][32][33][34] ¶ 72 Respect for the dignity of each individual—a fundamental right, protected by Article II, Section 4 of the Montana Constitution—demands that people have for themselves the moral right and moral responsibility to confront the most fundamental questions about the meaning and value of their own lives and the intrinsic value of life itself. See Dworkin, Life’s Dominion, at 110; Dworkin, Freedom, at 166.

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value of life in general, answering to their own consciences and convictions. Equal protection, also protected by Article II, Section 4, requires that people have an equal right to form and to follow their own values in profoundly spiritual matters. See Dworkin, Life's Dominion, at 165-67. Article II, Section 3, guarantees each person the inalienable right to seek safety, health and happiness in all lawful ways--i.e., in the context of this case, the right to seek and obtain medical care from a chosen health care provider and to make personal judgments affecting one's own health and bodily integrity without government interference. As already noted, Article II, Sections 5 and 7, protect, respectively, the freedom to accept or reject any religious doctrine, including those about abortion, and the right to express one's opinion in all lawful ways and forums. The right to due process of law, Article II, Section 17, protects those rights--including rights of personal and procreative autonomy--inherent in the historical concept of "ordered liberty." Finally, the right of individual privacy guaranteed by Article II, Section 10, requires the government to leave us alone in all these most personal and private matters.

¶ 73 Having made this observation, though, we must also note that each person's enjoyment of these various constitutional rights is not without a corresponding cost. In fact, Article II, Section 3, requires that those enjoying the inalienable rights set forth in that section "recognize corresponding responsibilities." Whatever may be this cost or corresponding responsibility, however, it does not include the demonization of women who choose to terminate their pregnancies at a time the law allows nor does it mandate the criminalization of providers of abortion services to these women. Likewise, this cost does not require the denigration and condemnation of those who, as a matter of their own good consciences, either favor or reject abortion. Most importantly, this cost does not permit the government's infringement of personal and procreative autonomy in the name of political ideology.

¶ 74 Rather, the price--the corresponding responsibility--for our commitment to the values and ideals of just government and for our enjoyment of our individual rights protected by Montana's Constitution is simply tolerance. And indeed, that is a token sum for, among other freedoms, the right to be let alone.

**384 Summary**

¶ 75 We hold that the core constitutional right infringed by the legislation at issue in the case at bar is the fundamental right of individual privacy guaranteed to every person under Article II, Section 10 of the Montana Constitution. We hold that the personal autonomy component of this right broadly guarantees each individual the right to make medical judgments affecting her or his bodily integrity and health in partnership with a chosen health care provider free from the interference of the government, except in very limited circumstances not at issue here. More narrowly, we hold that Article II, Section 10, protects a woman's right of procreative autonomy--here, the right to seek and to obtain a specific lawful medical procedure, a pre-viability abortion, from a health care provider of her choice. We also hold that the government has failed to demonstrate a compelling state interest for infringing upon these rights of privacy and that, therefore, the amendments to § 37-20-103, MCA, and § 50-20-109, MCA, enacted pursuant to Ch. 321, L.1995, prohibiting a physician assistant-certified from performing a pre-viability abortion under the supervision of a licensed physician are unconstitutional under Article II, Section 10, of the Montana Constitution.

¶ 76 The judgment of the District Court is affirmed.


Justice KARLA M. GRAY, specially concurring.

¶ 77 I concur in the Court's opinion to the extent it addresses the issue before us in this case. That is, I agree that the challenged statutory amendments are unconstitutional because they violate a woman's right of procreative autonomy protected by Article II, Section 10 of the Montana Constitution and the State has not demonstrated a compelling state interest for infringing on that right. I cannot join in other parts of the Court's opinion which, although scholarly written, are overly broad and far outside the scope of the issue actually before us. In concluding that Article II, Section 10 broadly guarantees each individual the right to make medical judgments affecting his or her bodily integrity and health in partnership with a chosen health care provider free from government interference, the Court's opinion sweeps so broadly as to encompass and decide such issues as the right to physician-assisted suicide and other important health and medical-related issues which simply were not litigated in this case. I cannot agree that it is appropriate to address such matters in this case and, indeed, it is my view that
much of the Court's opinion is *dicta*.

¶ 78 I am particularly troubled by that portion of the Court's opinion which states--without any analysis whatsoever--that the rights of personal and procreative autonomy at issue in this case also find protection in the individual dignity and equal protection rights set forth in Article II, Section 4; the inalienable right to seek safety, health and happiness in all lawful ways contained in Article II, Section 3; the religious and speech freedoms set forth in Article II, Sections 5 and 7; and the due process right contained in Article II, Section 17. That discussion is far beyond the scope of this case as presented and, in any event, is totally unsupported by the Court. While such thoughts appropriately might be included in a concurring opinion if supported by legal analysis, it is my view that they have no place in an opinion addressing and resolving the issue before us under the right to privacy contained in Article II, Section 10 of the Montana Constitution.

¶ 79 Finally, it is necessary to comment on those portions of the Court's opinion which discuss the propriety of leaving the determination of standards for medical practice in the hands of the medical community--acting through the medical examining and licensing authorities. I generally agree with the Court's discussion in those regards but I do not agree with any implicit notion therein that the Legislature has no place at all in the equation. It is important to keep in mind that the practice of medicine is a privilege, not a right, in Montana and that it is generally subject to legislative oversight in order to protect the health, safety, and welfare of the people of Montana. *See § 37-3-101, MCA.* Indeed, the Montana Board of Medical Examiners (Board) is an entity created by the Legislature via § 2-15-1841, MCA, and given the powers and duties set forth in § 37-3-203, MCA, for the purpose of ensuring that medical licensees conform to appropriate standards of conduct and exercise the privileges granted to them "in the greatest public interest." *Section 37-3-302, MCA.*

¶ 80 In discharging its oversight responsibility in the area of medical care for Montanans, however, the Legislature has expressly provided for the licensing of certified physician assistants who practice under the supervision of physicians pursuant to the terms of "utilization plans" approved by the Board. *See §§ 37-20-101, 37-20-203, and 37-20-301, MCA.* As provided by the Legislature, a certified physician assistant is "a member of a health care team, approved by the board, who provides medical services that may include examination, diagnosis, prescription of medications, and treatment, as approved by the board, under the supervision of a physician licensed by the board." *Section 37-20-401, MCA.* The utilization plan requiring Board approval must set forth the scope of the physician assistant's practice, and can be approved only if the physician assistant's practice is within the scope of the training, knowledge, experience and practice of the supervisory physician and also within the scope of the training, knowledge, education and experience of the certified physician assistant. *Sections 37-20-301(2)(c), (3)(b), and (3)(c), MCA.*

¶ 81 In the context of the present case, I agree with the Court that, once the statutory requirements for licensure of a certified physician assistant and for approval of the utilization plan covering that certified physician assistant have been satisfied, the Legislature cannot indirectly intrude into a utilization plan setting forth the scope of practice for that physician assistant which has been approved by the medical authorities empowered by the Legislature to do just that. Here, the Board had approved Cahill's utilization plan which permitted her to perform abortions, and it was inappropriate for the Legislature to substitute its judgment for that of the Board it created to oversee such matters involving the practice, training, knowledge, education and experience of medical personnel.

¶ 82 In summary, I join in those portions of the Court's opinion which address and resolve the issue actually before us. I do not join in those portions of the opinion which cast too wide a net and which implicitly *suggest that the Legislature has no role at all in matters relating to the health care to be provided to the people of Montana.*

Chief Justice J.A. TURNAGE joins in Justice GRAY's foregoing special concurrence.

296 Mont. 361, 989 P.2d 364, 1999 MT 261

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Supreme Court of Montana.
No. 13404.


Action was brought in which recovery was sought against referring orthodontist, oral surgeon and others on theory that dental malpractice occurred in diagnosis of plaintiff's problems in regard to gaps between his teeth and occurred in resultant partial glossectomy performed on plaintiff by the oral surgeon. The Thirteenth District Court, Yellowstone County, C. B. Sande, J., entered summary judgment in favor of defendants, and plaintiff appealed. The Supreme Court, John C. Harrison, J., held that plaintiff was not entitled to recover from referring orthodontist on theory that dental malpractice occurred in his diagnosis of plaintiff's problem or on theory that orthodontist was negligent in failing to warn plaintiff of the seriousness of the operation; that ear, nose and throat specialist was not qualified to testify as to the standard of care usually exercised by an oral surgeon or to testify that tonsils created an infected area in oral cavity which could have caused an infection to the tongue; that plaintiff was not entitled to recover from oral surgeon on theory that there was a 'lack of informed consent' to the operation by plaintiff; that evidence failed to indicate that plaintiff suffered any compensable damage or complication due to abnormal loss of blood and failed to support the allegations that the operation was unnecessary or unwarranted; and that plaintiff was not entitled to recover from oral surgeon on theory of breach of express warranty to obtain a specific result.

Orders affirmed.

West Headnotes

[1] Health 682
198HK682 Most Cited Cases
(Formerly 299K15(19) Physicians and Surgeons)
Plaintiff, on whom a partial glossectomy was performed by oral surgeon, was not entitled to recover from referring orthodontist on theory that dental malpractice occurred in his diagnosis of plaintiff's problem in regard to gaps between his teeth, in view of indication that there was no error in orthodontist's diagnosis that plaintiff's problem might be caused by a "tongue thrust."

[2] Health 786
198HK786 Most Cited Cases
(Formerly 299K16 Physicians and Surgeons)
Absent partnership, employment or agency, a referring physician cannot be subjected to liability in regard to his referral; the recommended physician is an independent contractor liable for his own torts.

[3] Health 908
198HK908 Most Cited Cases
(Formerly 299K15(8) Physicians and Surgeons)
Plaintiff, on whom a partial glossectomy was performed by oral surgeon, could not recover from referring orthodontist on theory that he was negligent in failing to warn plaintiff of the seriousness of such operation.

[4] Health 906
198HK906 Most Cited Cases
(Formerly 299K15(8) Physicians and Surgeons)
Physician who prepares to perform a medical or surgical procedure, rather than a referral doctor, has the obligation to explain the procedure to the patient.

[5] Health 926
198HK926 Most Cited Cases
(Formerly 299K18.80(8) Physicians and Surgeons)
Sufficiency of a physician's disclosure to patient, in regard to a medical or surgical procedure, is a matter to be measured against acceptable medical practice; a patient who seeks to recover from physician or theory that such disclosure was insufficient is required to produce expert testimony to establish a standard of medical practice and to show physician's deviation from that standard.

[6] Evidence 538
157K538 Most Cited Cases
In dental malpractice action against oral surgeon who performed partial glossectomy on plaintiff, ear, nose and throat specialist, whose only knowledge in regard to a partial glossectomy was knowledge obtained
through discussing such procedure with oral surgeons after he examined plaintiff before removing his tonsils, was not qualified to testify as to the standard of care usually exercised by an oral surgeon or to testify that tonsils created an infected area in oral cavity which could have caused an infection to the tongue.

[7] Health 908
198Hk908 Most Cited Cases
(Formerly 299k15(15) Physicians and Surgeons)
Plaintiff, on whom a partial glossectomy was performed by oral surgeon to correct tongue problem, was not entitled to recover from oral surgeon on theory that there was a "lack of informed consent" to the operation by plaintiff, absent any showing as to standards of dental care required in informing patient of the risk prior to performing such an operation.

[8] Health 823(10)
198Hk823(10) Most Cited Cases
(Formerly 299k18.80(3) Physicians and Surgeons)
In dental malpractice action against oral surgeon who performed partial glossectomy on plaintiff, evidence failed to indicate that plaintiff suffered any compensable damage or complication due to abnormal loss of blood and failed to support allegations that the operation was unnecessary or unwarranted.

[9] Health 682
198Hk682 Most Cited Cases
(Formerly 299k13, 299k16 Physicians and Surgeons)
Plaintiff, on whom a partial glossectomy was performed by oral surgeon, was not entitled to recover from oral surgeon on theory of breach of express warranty to obtain a specific result, in view of failure to show any reliance by plaintiff on such a warranty or to show existence of any such warranty.

[10] Health 665
198Hk665 Most Cited Cases
(Formerly 299k14(3), 299k14(4) Physicians and Surgeons)
Physician who agrees to perform a surgical operation must possess the skill and learning possessed by the average member of his profession in community and must use those skills and learning in a reasonable and prudent manner, but he does not become a guarantor of the results of the operation.

30k223 Most Cited Cases
Issue in regard to defendants' failure to give ten days' notice of time fixed for hearing their motions for summary judgment could not be raised by plaintiff on appeal from summary judgment where plaintiff failed to raise such issue before trial court. M.R.Civ.P., rules 56(c), 61.

[12] Appeal and Error 181
30k181 Most Cited Cases
An objection raised for first time on appeal is not timely and will not be considered by Supreme Court.

*256 **807 Lewis E. Brueggemann (argued), Billings, for appellant.

Anderson, Symmes, Forbes, Peete & Brown, Billings, Richard F. Cebull (argued), Billings, Weymouth Symmes (argued), Billings, Keefer & Roybal, Billings, J. Dwaine Roybal (argued), Billings, Neil Keefer, Billings, Crowley, Haughey, Hanson, Gallagher & Toole, Billings, Jack Ramirez (argued), Billings, for respondents.

JOHN C. HARRISON, Justice.

This is an appeal from summary judgment entered in favor of all defendants in a dental malpractice action in the district court, Yellowstone County.

Plaintiff Alan Llera brought action alleging malpractice resulting from an oral surgical procedure known as a partial glossectomy. Plaintiff alleges the malpractice occurred in the diagnosis of his problem and in the resultant operation. He alleges no informed consent was obtained nor were the risks and the alternatives to his tongue problem ever explained or discussed.

Plaintiff alleges Dr. Jon A. Jourdonnais, the referring dentist, gave Dr. Byron Wisnor no referral information at the time; that Dr. Hurly, the admitting doctor at St. Vincent's hospital found nothing wrong with his tongue but did find enlarged tonsils; that Dr. Hylton, the anesthesiologist and his agents were negligent in allowing the operation; that two nurses, D. Drake and M. Kemp, did not provide the proper care; and finally that St. Vincent's Hospital failed to exercise the proper degree of care for plaintiff.

*257 Plaintiff, a 20 year old man, went to see Dr. Jourdonnais, a Great Falls orthodontist, for treatment to reduce the gaps between his teeth. Dr. Jourdonnais, after treating plaintiff through the use of
February 23, 1973, in Billings. Dr. Wisner's 'tongue thrust'. Neither did he tell Dr. Wisner of his diagnosis as plaintiff's teeth but did not send his written diagnosis. Falls. Although a schedule was set up for plaintiff to hospital five days before returning home to Great employee of St. Vincent's. Plaintiff remained in the hospital five days before returning home to Great Services, assisted in the operation. One defendant, McGarity, respectively, members of M.D. Anesthesia and the anesthetist, Dr. Robert R. Hylton and J. *258 Wisner for oral surgery.

The anesthesiologist M. Kemp, who was trained and employed by Dr. During surgery Dr. Wisner was assisted by a nurse, M. Kemp, who was trained and employed by Dr. Wisner for oral surgery. *258 The anesthesiologist and the anesthetist, Dr. Robert R. Hylton and J. McGarity, respectively, members of M.D. Anesthesia Services, assisted in the operation. One defendant, D. Drake was the circulating nurse and was an employee of St. Vincent's. Plaintiff remained in the hospital five days before returning home to Great Falls. Although a schedule was set up for plaintiff to see Dr. Wisner after leaving the hospital, he returned only once, on July 20, 1973. In his deposition, Dr. Wisner testified that on that call plaintiff had no complaints. He also testified he did tell plaintiff there was a chance of some loss of tongue mobility, speech impairment, loss of taste, and possibly it might not cure his tongue thrust when he was informed by plaintiff that Dr. Jourdonnais had discussed the operation with him and he wanted the operation. However, Dr. Wisner did say he told plaintiff that it was a difficult procedure that should be done in the hospital. Plaintiff said his reason for wanting the operation was because of the spacing and flaring of his teeth and the operation might help remove the pressure on those teeth. While denied by plaintiff and his mother, Dr. Wisner stated in his deposition that she was in favor of her son having the operation.

During the one return visit to Dr. Wisner, no infection was noted in the tongue. On examination plaintiff also showed no taste nor sensory deficiency; the tongue had normal mobility and plaintiff could lick his lips.

The hospital records and depositions indicate that plaintiff lost from 1100 to 1500 cc of blood and that two blood transfusions were required. Plaintiff alleges that expert testimony would indicate that 200 to 300 cc is a normal loss in this type of operation and the loss of such a large amount is an evidentiary fact tending to prove the ultimate fact the operation was not performed properly.

Following the operation plaintiff returned to Great Falls and continued to have Dr. Jourdonnais do orthodontic work for him for some six months until plaintiff moved to Bozeman. Plaintiff stated in his deposition that when he went to see Dr. Wisner some six weeks after the operation his tongue was inflamed and that Dr. Wisner gave him some pills for the inflammation. Dr. Jourdonnais stated he had difficulty with plaintiff before and after the operation with plaintiff not keeping appointment dates, which interfered with his giving plaintiff constant care.

Some six months after the operation in Billings, plaintiff had his tonsils and adenoids removed in Great Falls by Dr. W. J. Roberts. In his deposition, Dr. Roberts stated that at the time of his removing the tonsils they were enlarged and infected and in his opinion this infection was chronic. However, he stated when he first examined plaintiff in October 1973, he found no acute infection. He further stated that while he doubted the tonsils would have interfered with the movement of plaintiff's tongue, the recurring inflammation could cause the tongue to be sore.

Five issues are presented all directed to the granting of summary judgment to defendants. These issues
can be summarized thus—Was summary judgment proper:

1) If there were genuine issues of fact as to any one or more of defendants?

2) Where plaintiff moved for a continuance to locate additional expert testimony?

3) Where there was expert testimony already before the court, or its equivalent?

4) As to any one or more, or all of defendants, as a matter of law as pertaining to any one or more of the three causes of action?

5) When defendants failed to comply with the notice requirements of Rule 56(c), M.R.Civ.P.?

We note here that plaintiff's complaint against the defendants sets forth three causes of action, the first for lack of informed consent, the second for failure to use due care, (both sounding in tort); and the third against only defendant Wisner for breach of express warranty to obtain a specific result. Extensive discovery procedures followed the filing of the complaint, including seven depositions, several sets of interrogatories, numerous exhibits, and including articles from dental publications that considered the treatment of an 'open bite' and 'tongue thrust' condition.

We have carefully reviewed the posture of the cause at the time all defendants filed motions for summary judgment and at the time such motions were heard. We affirm such summary judgments as to six defendants without further discussion other than to note we find the record concerning these six totally fails to disclose genuine issues of material fact on any theory of pleading advanced by plaintiff. These six defendants are: Robert R. Hylton, M.D.; J. McGarity, C.R.N.A.; M.D. Anesthesia Services; M. Kemp, R.N.; D. Drake, R.N.; and Saint Vincent's Hospital. See: Montana Deaconess Hospital v. Gratton, Mont., 545 P.2d 670, 33 St.Rep. 128; Collins v. Itoh, 160 Mont. 461, 503 P.2d 36; Maki v. Murray Hospital, 91 Mont. 251, 7 P.2d 228; Davis v. Trobough, 139 Mont. 322, 363 P.2d 727.

The summary judgment granted Dr. Jourdonnais and Dr. Wisner, will be discussed individually.

As to Dr. Jourdonnais, the summary judgment resulted after no facts were developed that revealed any deviation from the established standards of treatment by orthodontists and after if was shown that no harm came to plaintiff resulting from the treatment by Dr. Jourdonnais. It is of import to note that the court did not grant this defendant's motion for summary judgment until after plaintiff's attorney told the court he could not produce any additional expert witness testimony against Jourdonnais other than that before the court.

[1] The record is bare of any testimony of another orthodontist, dentist, medical doctor, or other expert that the professional service rendered plaintiff by this defendant was in any manner improper or negligent. In truth, plaintiff has no complaint as to the orthodontic work, but directs his complaints as to Jourdonnais' diagnosis and his failure to warn plaintiff of the seriousness of the operation called a 'partial glossectomy'.

Before the district court was the deposition of Dr. Morgan Allison, Ohio State University, an internationally recognized oral surgeon. His testimony shows clearly that there was no error in diagnosis by Dr. Jourdonnais and his treatment of plaintiff is a recognized and acceptable method of treatment.

[2] Here we have a referring doctor being faulted on the referral, because plaintiff is dissatisfied. We find no case law cited by plaintiff or by our research of the question, that holds a recommendation of a physician to another will subject the latter to liability for the recommendation, absent a showing of partnership or employment or agency. The recommended physician is treated as an independent contractor, liable for his own torts. Graddy v. New York Medical College, 19 A.D.2d 426, 243 N.Y.S.2d 940; Oldis v. La Societe Francaise de Bienfaisance Mutuelle, 130 Cal.App.2d 461, 279 P.2d 184; Huber v. Protestant Deaconess Hospital Ass'n, 127 Ind.App. 565, 133 N.E.2d 864; Myers v. Holborn, 58 N.J.L. 193, 33 A. 389; 70 C.J.S. Physicians and Surgeons s 54d, p. 978.

[3][4] We do not find plaintiff's allegation that defendant Jourdonnais was negligent due to the lack of informed consent supported by any evidence. Again we can find no case where liability for failure to inform is found against one other than the physician who undertakes the operation. Here, defendant Jourdonnais did not advise plaintiff on the surgical procedure because he did not have knowledge of it other than reading. He stated he explained to plaintiff that he knew of the procedure having been performed; he knew nothing about it; he did not recommend it; but if plaintiff felt his situation...
was serious enough in his own mind, and he wanted further information on the procedure, then he would put him in touch with Dr. Wisner. He told plaintiff he would put him in touch with Dr. Wisner for information only. On this basis he contacted Dr. Wisner, made an appointment for plaintiff, and sent all his records to Dr. Wisner. The rule is that the physician who prepares to perform a medical or surgical procedure has the obligation to explain that procedure to the patient—not the referral doctor. Watson v. Clutts, 262 N.C. 153, 136 S.E.2d 617; Mitchell v. Robinson, *262 (Mo.1960), 344 S.W.2d 11; Harwick v. Harris, (Fla.App., 1964), 166 So.2d 912.

[5] The accepted view is that the sufficiency of the physician's disclosure is a matter to the measured against acceptable medical practice. Plaintiff is required to produce expert testimony to establish a standard of medical practice and show defendant's deviation from that standard. Zebarth v. Swedish Hospital Medical Center, 81 Wash.2d 12, 499 P.2d 1. The record presented to the district court in the instant case lacks any evidence of a standard for an orthodontist, or of one that refers patients to another specialist. The testimony of Dr. Schultz, an oral surgeon of Great Falls, does not supply the standard necessary to sustain plaintiff position here.

We find summary judgment proper as to defendant Jourdanais.

The general fact situation as it relates to Dr. Wisner has been heretofore set out. He is a board certified oral surgeon who before practicing in Billings, served a three year residency under Dr. Morgan Allison of Ohio State University. Dr. Allison in his deposition stated Dr. Wisner was fully qualified to perform the 'partial glossectomy' and after reviewing all the depositions in this case, along with the records of the surgical procedure, he found no indication of any improper procedure on the part of Dr. Wisner in performing the operation.

With this background in mind, we review the background of this complaint. The operation was performed in June 1973. The complaint was filed March 5, 1975. Extensive discovery followed and the trial date of February 2, 1976 was continued to May 17, 1976 to complete such discovery. Motion for summary judgment was filed and served by defendant Wisner on May 17, 1976. After reviewing the depositions of Dr. Schultz and Dr. Jourdanais, which showed that after examining plaintiff after his operation they found no residual damage or evidence to sustain the problems he complained of, the court granted the motion for summary judgment on May 17, 1976.

*263 We note here that at the time of the hearing on summary judgment, the attorney for plaintiff did not object to notice on the hearing of less than the ten days allowed by statute, and admitted that he had no qualified expert testimony other than the depositions which this Court has read, all of which appears in the trial court's judgment.

All parties to this action agree that four cases control the issues before us. Donathan v. McConnell, 121 Mont. 230, 193 P.2d 819; **811 Neggaard v. Feda, 152 Mont. 47, 446 P.2d 436; Montana Deaconess Hospital v. Gratton, Mont., 545 P.2d 670, 33 St.Rep. 128, 130, 132; Collins v. Itoh, 160 Mont. 461, 503 P.2d 36.

Donathan established that in Montana a dentist owes the same duty as a physician to his patient.

In Gratton this Court held summary judgment is proper:

"* * * if the pleadings, depositions, answers to interrogatories, and admissions on file show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. * * *' Rule 56(c), M.R.Civ.P.' Also Gratton held that where no genuine issue of fact has been raised that the opposing party has the burden of presenting evidence of material and substantial nature raising such issue, noting that when plaintiff fails to do so, summary judgment must issue. The question of the establishment of a standard of care against which the acts or omissions could be measured to establish negligence is quoted from Evans v. Bernhard, 23 Ariz.App. 413, 533 P.2d 721, 723:

"* * * First, evidence must be presented to establish the applicable standard of medical practice in the particular type of case involved and second, it must also be shown that the doctor negligently departed from this recognized standard in his treatment of the plaintiff. In order to make this threshold breach of duty actionable, it must then be shown that the breach of duty was the legal cause of the plaintiff's injuries. * * * The medical standard of care must be established by expert medical testimony unless the conduct complained of is readily ascertainable *264 by a layman. * * * However, third party expert testimony is not always necessary as this standard can be established by the defendant doctor's own
Plaintiff in relying upon Donathan acknowledges that the rule established there controls this case. In a later case, Negaard the duties owed by a dentist were fully set forth, and those principles apply to the instant case.

At the time of the hearing on summary judgment, plaintiff here was in the same position as were the Grattons, appellants in Montana Deaconess Hospital in their appeal to this Court. Plaintiff complains of numerous factual issues principally relating to the diagnosis of his condition, the procedure used to correct it, and the treatment given him. If all the questions were resolved in his favor, he still could not prevail for he had no qualified expert testimony five days before trial date to show that defendant Wisner departed from the recognized standard of care in his treatment of plaintiff. The doctors he alleged as his experts were not 'deposed' and several indicated no intent to travel to Billings to testify on May 17, 1976.

[6] Plaintiff stated he intended to call, as experts, Drs. Baldwin and Roberts of Great Falls, however he previously admitted that Dr. Baldwin would not testify at trial or by deposition. So at the time of the summary judgment ruling, he was down to one possible witness Dr. W. J. Roberts, a physician whose testimony was to provide the standard of care for an oral surgeon. Dr. Roberts, a board certified ear, nose and throat specialist, undre the standard set by this Court in Collins, could not qualify as an expert against Dr. Wisner as to the standard of care that is usually exercised by an oral surgeon. This is true too as to his testimony about the fact the tonsils created an infected area in the oral cavity that could have caused an infection to the tongue. This Court in Gratton noted:

'The presence of an infection following an operation or open reduction of a fracture does not establish negligence. (Citing cases).'

[7] According to his deposition, Dr. Roberts knew nothing about a partial glossectomy until after he examined plaintiff before removing **812 his tonsils and the only knowledge he had was gained thereafter after discussing the procedure with oral surgeons in Great Falls.

[8] We next consider the blood loss issue. We find no testimony showing the loss of blood during the operation could result in plaintiff's alleged residual complications. Dr. Morgan Allison, defendant's expert, testified in his deposition that this was unusual bleeding for the partial glossectomy but went on to state that plaintiff did not suffer any complications from this loss because of the transfusions he received. We find no testimony of any of those deposed alleging plaintiff suffered any compensable damage or complication resulting from an abnormal loss of blood.

Next we consider plaintiff's allegations the operation was unnecessary and unwarranted. The record is devoid of any testimony supporting these allegations. Some doctors might have proceeded with a different treatment before resorting to the surgery, *266 but none testified that it was unnecessary or unwarranted. The choice was one of medical or dental judgment.

Plaintiff argues this Court's holding in Baylor v. Jacobson, Mont., 552 P.2d 55, 33 St.Rep. 662, is authority to allow him to go to the jury. He alleges there was expert testimony or its equivalent in the record indicating the operation should be performed only after 'everything else fails' and that the operation should not have been performed at all in this case. We do not agree. In Baylor the majority found an offer of proof of the required standard of care and the defendant's breach thereof in the medical testimony of a Dr. Robert Tuby whose identity the plaintiff revealed in an amended answer, filed a day after the summary judgment. Here, no expert medical testimony is available to establish any general issue of material fact concerning the required standard of care Dr. Wisner allegedly deviated from.

[9] [10] In plaintiff's complaint, as a third cause of action he alleged he agreed to pay defendant Dr.
Wisner $283.20, as consideration for his promise, warranty and performance of the operation. He alleges defendant breached this warranty, but plaintiff shows no reliance on same. The record indicates the amount plaintiff paid for the surgical procedure (the operation) but shows no warranty. While it is the law of Montana that if the contract was merely that defendant was to perform a surgical operation, then the law requires that the defendant possess the skill and learning possessed by the average member of his profession in the community and to use those skills and learning in a reasonable and prudent manner. He does not become a guarantor of the results of such operation.

We find summary judgment proper as to defendant Wisner.

[11][12] Plaintiff raises for the first time on appeal the failure to give at least ten days notice of time fixed for hearing the motions on summary judgments as required **813 by Rule 56(c), M.R.Civ.P. However, plaintiff fails to recognize that he must timely object to the rule requirement. Failure to do so waives the defect. *26710 Wright & Miller, Federal Practice and Procedure: Civil s. 2719, p. 451; 6 Moore's Federal Practice 56.14(1), p. 56-357. Also, plaintiff failed to raise his objection before the trial court. An objection raised for the first time on appeal is not timely and will not be considered by this Court. Berdine v. Sanders County, 164 Mont. 206, 520 P.2d 650; Carpenter v. Free, 138 Mont. 552, 357 P.2d 882. See also: Rule 61, M.R.Civ.P.

The orders of the district court granting summary judgments are affirmed.

JAMES T. HARRISON, C. J., HASWELL, J., and JACK L. GREEN, District Judge,* concur.

FN* Sitting for CASTLES, J.

171 Mont. 254, 557 P.2d 805

END OF DOCUMENT
United States District Court, D. Montana,
Missoula Division.
Jane DOE and James Armstrong, M.D., Plaintiffs, v.
Robert L. DESCHAMPS, III, Missoula County
Attorney, H. James Oleson, Flathead County
Attorney, and Robert L. Woodahl, Attorney General
for the State of Montana, Defendants. - 461 F.Supp. 682

No. CV 74-120-M.

Nov. 5, 1976.

Action was brought challenging validity of various
provisions of the Montana Abortion Control Act, and
regulations promulgated thereunder. A Three-Judge
District Court held that: (1) informed consent
requirement was constitutionally valid; (2) spousal
notice requirement as written was unconstitutional;
(3) married woman lacked standing to challenge
requirement of notice to parents of woman under age
18 and unmarried; (4) criminal liability provision
with respect to viable infant born alive was
constitutional; (5) plaintiffs lacked standing to
challenge dependent and neglected child provisions;
(6) requirement of concurrence of two additional
physicians after viability of fetus was constitutional;
(7) section prohibiting soliciting and advertising was
unconstitutional, and (8) record-keeping and
reporting requirements were constitutional.

Ordered accordingly.

West Headnotes

[1] Abortion and Birth Control 4 ©1.21

4 Abortion and Birth Control
4k.20 Constitutional and Statutory Provisions
4k.21 k. In General. Most Cited Cases
(Formerly 4k.20)
Informed consent provisions of Montana Abortion
Control Act were constitutionally valid. R.C.M.1947, § 94-5-615(3), 94-5-616(1).

[2] Abortion and Birth Control 4 ©1.21

4 Abortion and Birth Control
4k.20 Constitutional and Statutory Provisions
4k.21 k. In General. Most Cited Cases
(Formerly 4k.20)
Spousal notice requirement of Montana Abortion
Control Act, as written, was unconstitutional where
statute failed to specify a conclusive and
uncontrollable method of giving notice to husband
whereby pregnant woman and physician could be
certain that criminal liability would be avoided.
R.C.M.1947, § 94-5-616(2).

[3] Constitutional Law 92 ©42(1)

92 Constitutional Law
92k. Construction, Operation, and Enforcement of
Constitutional Provisions
92k41 Persons Entitled to Raise Constitutional
Questions
92k42 In General
92k42(1) k. In General. Most Cited
Cases
Married woman lacked standing to challenge
constitutionality of provision of the Montana
Abortion Control Act requiring written notice to
parents of woman who is under 18 years of age and


203 Homicide
203k. Murder
203k521 Constitutional and Statutory
Provisions
203k523 k. Validity. Most Cited Cases
(Formerly 203k8)
Section of the Montana Abortion Control Act
providing that person commits offense of criminal
homicide if he purposely, knowingly or negligently
causes death of premature infant born alive, if such
infant is viable, was not constitutionally
objectionable. R.C.M.1947, § § 94-5-615(5), 94-5-
617(1).

[5] Constitutional Law 92 ©42(1)

92 Constitutional Law
92k. Construction, Operation, and Enforcement of
Constitutional Provisions
92k41 Persons Entitled to Raise Constitutional
Questions
92k42 In General
92k42(1) k. In General. Most Cited
Cases
Neither physician nor pregnant woman who made no
showing that she would be affected in any way by
challenging provision of statute had standing to
challenge constitutionality of provision of the
Montana Abortion Control Act providing, with two
exceptions, that premature infant who has been subject of abortion is a dependent and neglected child and thus a ward of the state. R.C.M.1947, § 94-5-617(2).

[6] Abortion and Birth Control 4 1.21

Abortion and Birth Control 4k1.20 Constitutional and Statutory Provisions 4k1.21 k. In General. Most Cited Cases (Formerly 4k1.20)

Requirement of Montana Abortion Control Act for concurrence of two additional physicians before abortion may be performed after viability of the fetus is constitutionally permissible. R.C.M.1947, § 94-5-618(1)(c).

[7] Abortion and Birth Control 4 0.5

Abortion and Birth Control 4k0.5 k. Right to Abortion and Regulation Thereof. Most Cited Cases (Formerly 4k0.50, 4k50)

Up to point of fetal viability, abortion decision must be left to the pregnant woman and her attending physician with but minimal state regulation; after the fetus becomes viable, emphasis switches to concern for the preservation of the potentiality of life compatible with the health of the mother.

[8] Abortion and Birth Control 4 1.21

Abortion and Birth Control 4k1.20 Constitutional and Statutory Provisions 4k1.21 k. In General. Most Cited Cases (Formerly 4k1.20)

Section of the Montana Abortion Control Act prohibiting soliciting and advertising was unconstitutional. R.C.M.1947, § 94-5-618(3).

[9] Abortion and Birth Control 4 1.21

Abortion and Birth Control 4k1.20 Constitutional and Statutory Provisions 4k1.21 k. In General. Most Cited Cases (Formerly 4k1.20)

Record-keeping and reporting requirements of the Montana Abortion Control Act are constitutionally permissible, assuming that they will not be administered in an unduly burdensome matter. R.C.M.1947, § 94-5-619.

*683 James B. Wheelis, Datsopoulos & McDonald, Missoula, Mont., American Civil Liberties Union by Judith M. Mears, Director, Reproductive Freedom Project, ACLU, New York City, for plaintiffs.

Robert L. Woodahl, pro se.

John F. North, Thomas J. Beers, Helena, Mont., for defendant Woodahl.

Dennis E. Lind, Deputy County Atty., Missoula, Mont., for defendant Deschamps.

H. James Oleson, pro se.

Patrick M. Springe r, County Atty., Kalispell, Mont., for defendants.

Before BROWNING, Circuit Judge, and SMITH and JAMESON, District Judges.

ORDER and MEMORANDUM OPINION

PER CURIAM:

Following the decision of this court in Doe v. Woodahl, 360 F.Supp. 20 (D.Mont.1973), holding invalid Montana statutes regulating abortion, the Montana legislature in 1974 enacted the Montana Abortion Control Act, R.C.M.1947, s 94-5-613, Et seq., with the intent “to restrict abortion to the extent permissible under decisions of appropriate courts or paramount legislation”. s 94-5-623. Plaintiff Jane Doe is a married woman who was pregnant when this action was filed. She arranged with plaintiff James Armstrong, M.D. for an abortion. The abortion was performed in the course of Dr. Armstrong's regular medical practice. Both plaintiffs complied with the Montana Abortion Control Act. They brought this action challenging the validity of various provisions of the Act and the regulations promulgated thereunder and sought to enjoin their enforcement.

This three-judge court was convened pursuant to 28 U.S.C. s 2281. Following submission of briefs it was learned that some of the issues raised in this action were before the Supreme Court. Accordingly an order was entered on December 31, 1975 deferring submission of this case until the decisions of the Supreme Court of the United States in Planned Parenthood of Central Missouri v. Danforth, No. 74-1151, and Danforth v. Planned Parenthood of Central Missouri, No. 74-1419 became final. These were appeals by the respective parties from a judgment entered in an action instituted by Planned Parenthood of Central Missouri challenging the constitutionality of Missouri statutes on abortion. The case was decided by the Supreme Court on July 1, 1976,[FN1] 428 U.S. 52, 96 S.Ct. 2831, 49 L.Ed.2d 788. Accordingly this court is now in a position to render its decision on the constitutionality of the questioned provisions of the Montana Act in the light of the Supreme Court guidelines on abortion regulation.

Challenged Provisions

The plaintiffs contend that the following provisions are unconstitutional on their face:

(1) Section 94-5-616(1) making it a misdemeanor for a physician to perform an abortion in the absence of informed consent which, as defined by s 94-5-615(3), requires the physician to certify on state supplied forms that the patient has been advised of the nature of the surgical procedure, its consequences and alternatives, and that the patient has voluntarily consented to the procedure.

(2) Section 94-5-616(2) prohibiting any abortion to be performed unless a written notice is provided to the woman's husband, unless she is separated, or to the woman's parents if she is under 18 years of age and unmarried.

(3) Section 94-5-617(1) providing criminal liability for any person causing the death of a viable fetus delivered during an abortion. The term “viable” is defined in s 94-5-615(5) as meaning “the ability of a fetus to live outside the mother's womb, albeit with artificial aid”.

(4) Section 94-5-617(2) providing that a premature infant who was the subject of an abortion is a dependent and neglected child and thus a ward of the state unless (a) the abortion was required to preserve the life of the mother, or (b) the parents agree within 72 hours after the abortion to accept parental rights.

(5) Section 94-5-618(1)(c) requiring that the attending physician obtain the consent of two additional physicians before performing an abortion not necessary to save the woman’s life in cases where the woman is carrying a viable fetus.

(6) Section 94-5-618(3) prohibiting the solicitation, advertising or other communication having the purpose of inviting, inducing, or attracting a person to have an abortion or purchase abortifacients.

(7) Section 94-5-619 establishing reporting requirements for physicians and medical facilities performing abortions and requiring pathology studies and reports on aborted fetuses; and authorizing the State Department of Environmental Sciences to promulgate regulations with respect thereto.

Guidelines for determining the constitutionality of state statutes and regulations on abortion were established in Roe v. Wade, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973) and Doe v. Bolton, 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed.2d 201 (1973). As the Court noted in Planned Parenthood v. Danforth, that case is a “logical and anticipated corollary” to Roe And Doe and presented questions forecast and reserved in Roe and Doe.

In Roe v. Wade, the Court held invalid a state law making abortions illegal except when necessary to preserve the life of the mother. The Court found an unconstitutional interference with the woman's right of privacy which encompassed her decision of whether to terminate her pregnancy. The Court stressed, however, that the woman's right was not absolute, but rather must be balanced against the state's right to protect potential life and safeguard maternal and infant health. In balancing these interests, the Court concluded at 410 U.S. 164-66, 93 S.Ct. 732-33:

“1. A state criminal abortion statute of the current Texas type, that excepts from criminality only a Life-saving procedure on behalf of the mother, without regard to pregnancy stage and without recognition of other interests involved, is violative of the Due Process Clause of the Fourteenth Amendment.

(a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.

(b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.

(c) For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother . . .

(This) decision leaves the State free to place increasing restrictions on abortion as the period of pregnancy lengthens, so long as those restrictions are
tailored to the recognized state interests. The decision*685 vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician."

Doe v. Bolton involved the validity of a more modern abortion statute which allowed the physician to give abortions in accordance with “his best clinical judgment”. The Court upheld that standard, but struck down provisions of the statute which required that (1) abortions be given only in certain accredited hospitals; (2) the hospital board of directors give approval to any abortion; and (3) two physicians in addition to the attending doctor acquiesce in the decision. The Court held that these requirements were constitutionally invalid because they failed to distinguish between the changing degree of state interests during the three trimesters of pregnancy and because they unduly infringed on the patient's and physician's rights.

In Planned Parenthood v. Danforth the Court resolved some of the questions left unanswered in Roe and Doe and refined further the standards set forth in those cases in ruling on the validity of a state law enacted for the express purpose of limiting abortions under the Roe and Doe guidelines.

The Court upheld the definition of fetal viability, which was framed in terms of Roe’s language “potentially able to live outside the mother's womb, albeit with artificial aid”. 410 U.S. at 160, 93 S.Ct. at 730. The Court found constitutionally permissible a provision requiring the physician to insure that the woman gave “informed consent” to the abortion before it was performed. Also upheld were record keeping and reporting requirements which the Court found to have medical value. The Court, however, held unconstitutional four provisions of the Missouri law:

First, a provision requiring spousal consent for married women was found to be an unconstitutional attempt to delegate a veto power to a spouse which the state itself “was prohibited from exercising during the first trimester of pregnancy”.

Second, for substantially the same reasons the Court found invalid a blanket parental consent requirement with respect to an under-18-year-old pregnant minor.

Third, the Court held that the State could not prohibit a specific type of abortion procedure where the regulation was not a reasonable protection of maternal health.

Fourth, a provision requiring a physician to preserve a fetus' life and health was found invalid since it did not define the physician's duty in terms of the viability of the fetus.

Although in Planned Parenthood v. Danforth the Court addressed new issues not raised in Roe and Doe, it was stressed throughout the opinion of the Court that the methodology set forth in the earlier decisions, which based the state's right to regulate abortions on the viability of the fetus as determined by the stage of pregnancy in which the abortion was being performed, was still the standard to be utilized in determining the constitutionality of state abortion statutes. In light of this background we turn to an analysis of the challenged provisions.

Informed Consent Requirement

[1] In Planned Parenthood v. Danforth the Court upheld an informed consent requirement of the Missouri statute similar to ss 94-5-616(1) and 615(3). While the Missouri statute did not go as far as the Montana statute in describing the information the physician must give his patient, it seems clear from the language of the Court that the Montana statute would also meet the constitutional test. The Court said in part:

“It is true that Doe and Roe clearly establish the State may not restrict the decision of the patient and her physician regarding abortion during the first stage of pregnancy. Despite the fact that apparently no other Missouri statute, with *686 the exceptions referred to in n. 6, Supra, requires a patient's prior written consent to a surgical procedure, the imposition by s 3(2) of such a requirement for termination of pregnancy even during the first stage, in our view, is not in itself an unconstitutional requirement. The decision to abort, indeed, is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences. The woman is the one primarily concerned, and her awareness of the decision and its significance may be assured, constitutionally, by the State to the extent of requiring her prior written consent.

“We could not say that a requirement imposed by the State that a prior written consent for any surgery would be unconstitutional. As a consequence, we see no constitutional defect in requiring it only for some types of surgery as, for example, an intracardiac procedure, or where the surgical risk is elevated above a specified mortality level, or, for that matter,

We hold that the provisions of ss 94-5-616(1) and 615(3) are constitutionally valid.

Notice Requirements

Spousal Notice

[2] In Planned Parenthood v. Danforth, the Court considered a Consent requirement rather than a Notice requirement. The spousal consent requirement was held invalid because the Court found that requiring the husband to consent to an abortion was equivalent to giving him a veto power over the decision. The Court said, “(W)e cannot hold that the State has the constitutional authority to give the spouse unilaterally the ability to prohibit the wife from terminating her pregnancy, when the State itself lacks that right . . . Inasmuch as it is the woman who physically bears the child and who is the more directly and immediately affected by the pregnancy, as between the two, the balance weighs in her favor.” The Court recognized that “It seems manifest that, ideally, the decision to terminate a pregnancy should be one concurred in by both the wife and her husband”. 428 U.S. at 70-71, 96 S.Ct. at 2841-42. It was the unilateral right of veto in the husband the Court found constitutionally repugnant.

The Montana statute does not require the consent of the spouse. Section 94-5-616(2) provides:

“No abortion may be performed upon any woman in the absence of:
(a) the written notice to her husband, unless her husband is voluntarily separated from her;“

The statute does not prescribe the method of giving notice and makes no provision for constructive notice. In the absence of a provision specifying a conclusive and uncontroversible method of giving notice, neither the pregnant woman nor the doctor could be certain that in a post-abortive action the fact that notice had been given would not be attacked and a criminal liability established. In our opinion the statute is unduly restrictive and does not afford adequate protection for either the physician or the pregnant woman seeking an abortion. In view of this conclusion, we do not reach the question of whether any notice requirement may be constitutional. We simply hold that s 94-5-616(2) as written is unconstitutional.

Parental Notice

[3] Section 94-5-616(2)(b) requires “the written notice to a parent, if living, or the custodian or legal guardian of such woman, if she is under eighteen (18) years of age and unmarried”. While the parties in their briefs argue the validity of this provision, the question was not raised in the pleadings. Obviously plaintiff Doe lacks standing to object to the provision. Since the plaintiff Armstrong did not raise the question in the complaint, we do not believe this issue is properly before the court. [FN2]

FN2. As the Court said in Singleton v. Wulff, supra, “Federal courts must hesitate before resolving a controversy, even one within their constitutional power to resolve, on the basis of the rights of third persons not parties to the litigation”. 428 U.S. at 113, 96 S.Ct. at 2874.

*687 Criminal Liability Provision

[4] Section 94-5-617(1) provides that, “A person commits the offense of criminal homicide, as defined in ss 94-5-101 through 94-5-104, if he purposely, knowingly, or negligently causes the death of a premature infant born alive, if such infant is viable.” “Viable” is defined in s 94-5-615(5) as “the ability of a fetus to live outside the mother's womb, albeit with artificial aid”.

The same definition of “viable” was approved in Planned Parenthood v. Danforth. The Court held, however, that a statute imposing criminal liability on one who fails to exercise the proper degree of professional skill to “preserve the life and health of the fetus” was invalid, noting that the statute did not “specify that such care need be taken only after the stage of viability has been reached”. The Court noted further that a “criminal failure to protect a liveborn infant surely will be subject to prosecution in Missouri under the State's criminal statutes”. 428 U.S. at 83-84, 96 S.Ct. at 2848.

The Montana statute is limited to an infant who is “viable”. While perhaps unnecessary in view of the criminal statute on homicide, we can see no constitutional objection to s 94-5-617(1).

Dependent and Neglected Child Provision

[5] The Missouri statute construed in Planned Parenthood declared an infant, who survives “an attempted abortion which was not performed to save the life or health of the mother,” to be “an abandoned ward of the state under the jurisdiction of the juvenile
court” and that the mother and the father too, if he consented to the abortion “shall have no parental rights or obligations whatsoever relating to such infant”. 428 U.S. at 62, n.2, 96 S.Ct. at 2838, n.2. The Court held in Planned Parenthood that the physician-appellants did not have standing to challenge this provision of the Missouri Act, since they did not claim any interest “sufficiently concrete” to satisfy the “case or controversy” requirement, citing Singleton v. Wulff. The district court had not decided whether Planned Parenthood had standing to challenge the Act, and the Court left this question to the district court for reconsideration on remand.

Under the holding in Planned Parenthood, plaintiff Armstrong clearly lacked standing to challenge s 94-5-617(2). Nor is there any showing that plaintiff Doe would be affected in any way by this provision of the statute. We hold accordingly that neither plaintiff had standing to question this section.

Physician Concurrence in Late Term Abortion

[6] Section 94-5-618(1)(c) provides that no abortion may be performed “(a)fter viability of the fetus, unless in appropriate medical judgment the abortion is necessary to preserve the life or health of the mother”. The physician is required to set forth in detail the facts upon which he relies in making his judgment, and two other licensed physicians must examine the patient and “concur(red) in writing with such judgment”. Plaintiffs challenge the requirement for concurrence of two other physicians.

As noted Supra, it was held in Roe v. Wade that for the “stage subsequent to viability” the State may regulate and even proscribe abortion “except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother”. (Emphasis added.) 410 U.S. at 164-165, 93 S.Ct. at 732. In Doe v. Bolton, the Court held unconstitutional a requirement for the concurrence of two physicians in all abortions. The Court recognized that, “Time, of course, is critical in abortion” and “Risks during the first trimester of pregnancy are admittedly lower than during later months”. In holding the concurrence requirement invalid the Court said:

“The statute's emphasis, as has been repetitively noted, is on the attending physician's 'best clinical judgment that an abortion is necessary.' That should be *688 sufficient. . . . If a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment. If he fails in this, professional censure and deprivation of his license are available remedies. Required acquiescence by co-practitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice. The attending physician will know when a consultation is advisable the doubtful situation, the need for assurance when the medical decision is a delicate one, and the like.” 410 U.S. at 199, 93 S.Ct. at 751.

Standing alone, this language in Doe suggests that any requirement for the concurrence of additional physicians would be invalid. As the Court stated in Roe, however, the opinions in Doe and Roe must be read together. In Roe the Court continued in part:

“. . . The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention.” 410 U.S., at 165-166, 93 S.Ct. at 733.

Moreover, it may be noted that in Roe the Court uses the phrase “appropriate medical judgment” in prescribing guidelines for the “stage subsequent to viability”, whereas in referring to the “stage prior to approximately the end of the first trimester” the Court uses the phrase “medical judgment of the pregnant woman's attending physician”. 410 U.S. at 164-165, 93 S.Ct. at 732.

The requirement of the Montana Act for concurrence of two physicians is limited to the period “after viability of the fetus”. [FN3] While a close question is presented and plausible arguments may be made in support of either position, on balance and considering the decisions of the Supreme Court as a whole, we conclude that the Montana statute is permissible under the language used in Roe.

FN3. The Georgia statute held invalid in Doe is distinguishable from the Montana statute in two respects: (1) the Georgia statute provided that an abortion was not criminal if performed pursuant to a physician's “best clinical judgment that an abortion is necessary”, whereas the Montana statute requires “appropriate medical judgment”; and (2) the Georgia statute covered abortions at all stages of pregnancy, whereas Montana's statute is limited to the trimester after viability, when the State's interest is most compelling.

[7] Up to the point of fetal viability the abortion decision must be left to the pregnant woman and her...
attending physician with but the minimal kind of State regulation approved in this opinion. After the fetus becomes viable, however, the emphasis switches, and the concern is for the preservation of the “potentiality of life” compatible with the health of the mother. “State regulation protective of fetal life after viability thus has both logical and biological justifications.” Roe, 410 U.S. at 163, 93 S.Ct. at 732.

The will of the woman and her physician are no longer of primary consideration. Medical judgments may vary greatly in this complex area, and the State may properly require more than the opinion of the woman's attending physician to insure that the potentiality of life is not destroyed.

We hold that s 94-5-618(1)(c) is constitutionally valid.

Prohibiting Solicitation and Advertising

Section 94-5-618(3) of the Montana Act provides that, “No physician, facility, or other person or agency shall engage in solicitation, advertising, or other form of communication having the purpose of inviting, inducing, or attracting any person to come to such physician, facility, or other person or agency to have an abortion or to purchase abortifacients”.

In Bigelow v. Virginia, 421 U.S. 809, 95 S.Ct. 2222, 44 L.Ed.2d 600 (1975), the Court construed a Virginia statute providing that, “If any person, by publication, lecture, advertisement, or by the sale or circulation of any publication, or in any other manner, encourage or prompt the procuring of abortion or miscarriage, he shall be guilty of a misdemeanor”. The Court reversed a judgment of the Supreme Court of Virginia *689 upholding the conviction of the managing editor of a newspaper which published an advertisement of a New York organization announcing that it would arrange low-cost placements for women with unwanted pregnancies. The Court concluded that Virginia could not apply its statute “to appellant's publication of the advertisement in question without unconstitutionally infringing upon his First Amendment rights”. 421 U.S. at 822, 95 S.Ct. at 2232.

We conclude that s 94-5-618(3) is unconstitutional.

Recordkeeping and Reporting Requirements

In Planned Parenthood the Court, in upholding recordkeeping and reporting provisions of the Missouri Act, held that, “Recordkeeping and reporting requirements that are reasonably directed to the preservation of maternal health and that properly respect a patient's confidentiality and privacy are permissible”. The Court added these words of caution:

“We naturally assume, furthermore, that these recordkeeping and record-maintaining provisions will be interpreted and enforced by Missouri's Division of Health in the light of our decision with respect to the Act's other provisions, and that, of course, they will not be utilized in such a way as to accomplish, through the sheer burden of recordkeeping detail, what we have held to be an otherwise unconstitutional restriction.” 428 U.S. at 80-81, 96 S.Ct. at 2846-2847.

While the recordkeeping and reporting provisions of s 94-5-619 of the Montana Act are more detailed than similar provisions of the Missouri Act, we conclude that they are constitutionally permissible. We assume, as did the Supreme Court in Planned Parenthood, that they will not be administered in an unduly burdensome manner.

Conclusion

In summary, we hold that the following provisions of the Montana statute are constitutionally valid:

(1) s 94-5-616(1) and 615(3) relating to informed consent.
(2) s 94-5-617(1) relating to the offense of criminal homicide.
(3) s 94-5-618(1)(c) relating to physician concurrence in late abortions.
(4) s 94-5-619 relating to recordkeeping and reporting.

We hold, for the reasons stated, that the following provisions are unconstitutional:

(1) s 94-5-616(2)(a) relating to spousal notice.

(2) s 94-5-618(3) relating to soliciting and advertising.

We hold that neither plaintiff has standing to challenge s 94-5-617(2) relating to dependent and neglected children; and that the question of the constitutionality of s 94-5-616(2)(b) is not properly before the court.

D.C.Mont., 1976.
Doe v. Deschamps
461 F.Supp. 682

END OF DOCUMENT
Medical malpractice action. The 13th District Court, Yellowstone County, Charles Luedke, J., directed a verdict for defendant, and plaintiff appealed. The Supreme Court, John C. Harrison, J., held that fact that operation on minor plaintiff failed to reveal a hernia as previously diagnosed by defendant physician, with result that plaintiff was left with two scars on her lower abdomen, was not sufficient to establish a prima facie case of negligence against defendant, absent a showing that defendant acted without ordinary care, diligence and skill, that he did not make a proper and skillful diagnosis, or that he deviated from established proper medical procedure as practiced in his neighborhood.

Affirmed.

**West Headnotes**

**1** Health 906

198Hk906 Most Cited Cases

(Formerly 299k15(15), 299k15(8)
Physicians and Surgeons)

Duty of physician to disclose in order to assure that an informed consent is obtained from patient is limited to those disclosures which a reasonable practitioner would make under similar circumstances; accordingly, if physician obtains an informed consent and proceeds as a competent medical man would in a similar situation, his course of action should not be questioned.

**2** Health 911

198Hk911 Most Cited Cases

(Formerly 299k15(15) Physicians and Surgeons)

Doctrine of an informed consent on part of patient or one acting in patient's behalf was not applicable to situation wherein minor plaintiff underwent a simple operation for repair of a supposed hernia to which mother had previously given her written consent, even though a failure to find a hernia on plaintiff's left side as previously diagnosed necessitated the opening of plaintiff's right side, since there were no dire consequences to be suffered as a result of opening child's right side, the worst possible consequence being the creation of a small needless scar in a generally covered area of the body.

**3** Health 637

198Hk637 Most Cited Cases

(Formerly 299k15(15) Physicians and Surgeons)

If a physician fails to make a properly skillful and careful diagnosis and makes an incorrect diagnosis, he may be held liable to patient for damage thus caused.

**4** Negligence 1652

272k1652 Most Cited Cases

(Formerly 272k134(1))

When a plaintiff produces evidence that is consistent with a hypothesis that the defendant is not negligent, and also with one that he is, his proof tends to establish neither.

**5** Health 823(5)

198Hk823(5) Most Cited Cases

(Formerly 299k18.80(3), 299k18(8)
Physicians and Surgeons)

Fact that operation on minor plaintiff failed to reveal a hernia as previously diagnosed by defendant physician, with result that plaintiff was left with two scars on her lower abdomen, was not sufficient to establish a prima facie case of negligence against defendant, absent a showing that defendant acted without ordinary care, diligence and skill, that he did not make a proper and skillful diagnosis, or that he deviated from established proper medical procedure as practiced in his neighborhood.

**347** **477** Joseph P. Hennessy, argued, Billings, for appellant.

Anderson, Symmes, Forbes, Peete & Brown, Weymouth D. Symmes, argued, Billings, for respondent.

**JOHN C. HARRISON**, Justice.

Defendant in this medical malpractice action was granted a directed verdict at the close of the plaintiff's evidence. Plaintiff's motion for a new trial was denied and this appeal is taken from the denial of that motion and from the directed verdict.

**478** During October 1965, Denille Doerr, plaintiff herein, was taken to the Billings Clinic by her mother
to see a pediatrician named Dr. Bruce L. Anderson. The girl was then 8 years old and had developed a small lump on her lower public area. Her mother told Dr. Anderson that the child had fallen from her bicycle and the lump seemed to develop after that accident. Dr. Anderson examined the child, told the mother the lump might be a hernia and referred her to Dr. Arthur J. Movius, defendant herein.

Dr. Movius is a general surgeon associated with the Billings Clinic. His speciality includes abdominal surgery. Dr. Movius examined the child a few days after Dr. Anderson had examined her and finding an irreducible mass just outside the left inguinal ring which looked like a hernia and felt like an extruded hernial sac, he diagnosed a probable left inguinal hernia.

Dr. Movious recommended that the child be operated on to repair the apparent defect. The mother signed the written consent form provided by the hospital and the operation took place on October 27, 1965. During the operation Dr. Movius discovered that the lump on the child's public area was caused by a fatty pad and there was no hernia of any type on the left side. It was not necessary to cut any muscle layers, only the skin was opened. Dr. Movius then asked the surgical nurse to notify the mother that there was no hernia on the left side and to seek the mother's permission for him to operate on the right side of the child to determine if there was a hernia there. The mother gave the surgical nurse the oral consent and Dr. Movius made an incision on the right side, again only penetrating through the skin. He found no evidence of any hernia and closed the incision.

At the trial plaintiff called Dr. Movius as an adverse witness and questioned him about the diagnostic procedures used to discover the existence of different types of hernias. Particular attention was devoted to hernias in small children, and Dr. Movius explained that the smallness of children's body structures and the softness of their tissues make it much more difficult to correctly diagnose a hernia in a child. He also testified that medical texts report 66% of children with a hernia will have one on each side of the abdomen, rather than a single hernia on one side of the absomen only; that occasionally hernia operations on children will determine that the hernia is actually on the side opposite the suspected side.

Dr. Movius admitted that his diagnosis of a probable hernia was wrong and stated he had never seen a fatty pad such as this before. There was no damage to the girl except the two scars on her lower abdomen.

The principal issue in this case is whether the court erred in directing the verdict for the defendant.

*349 Plaintiff contends that a prima facie case was established by a showing of absence of an informed consent on the part of the patient or one acting in her behalf; by a showing of a deviation by the doctor from an established proper medical procedure; and, that either showing is sufficient to establish a prima facie case of negligence.

[1] The general rule on informed consent was set forth by this Court in Negaard v. Estate of Feda, Mont., 446 P.2d 436, 25 St.Rep. 632. The duty to disclose to assure that an informed consent is obtained was recognized and described as a matter of medical judgment. This duty to disclose was limited to those disclosures which a reasonable practitioner would make under similar circumstances. If the doctor obtained an informed consent and proceeded as a competent medical man would in a similar situation, his course of action should not be questioned.

'The gist of the 'informed consent' theory of liability is that a physician is under a duty under some circumstances to warn his patient of consequences between the cases cited above and this simple operation for the repair of a supposed hernia to which the mother had previously given her

written consent. In this case there were no dire consequences to be suffered as a result of opening the child's right side. The worst possible consequence of expanding the operation to open the right side would be to create a small needless scar in a generally covered area of the body.

[3] Plaintiff contends that a prima facie case of negligence can be established by showing a deviation from established proper medical procedure. In this case it must be noted that the only medical testimony produced by the plaintiff was that of Dr. Movius as an adverse witness. There is no other medical testimony direct, indirect or circumstantial refuting the defendant's contention that only a diagnostic error had been made. If a physician fails to make a properly skillful and careful diagnosis and makes an incorrect diagnosis, he may be held liable to the patient for the damage thus caused. Bakewell v. Kahle, 125 Mont. 89, 93, 232 P.2d 127.

'Nor is an incorrect diagnosis of itself sufficient to establish liability. The plaintiff must show that such mistake was due to failure to use ordinary care and diligence and to exercise reasonable learning, skill and judgment in his examination and treatment.' Schumacher v. Murray Hospital, 58 Mont. 447, 467, 193 P. 397, 403.

'The undertaking of the physician is not to cure the patient, nor to insure that his treatment will be successful, but rather that he will treat the injury he is employed to treat with ordinary care, diligence and skill. His obligation requires only that he shall in his treatment employ such a degree of skill and diligence as surgeons practicing in the general neighborhood, pursuing the same line of practice, ordinarily display in like cases.' Dunn v. Beck, 80 Mont. 414, 422, 260 P. 1047, 1050.

Testimony at the trial indicated what procedure is followed and what tests are used to diagnose a hernia; that bilateral hernias are common in children; and, that difficulties inherent in examining children will occasionally result in an operation on the wrong side of the child. Two doctors examined the child and both diagnosed the probable existence of a hernia. The only test to determine if the lump was a fat pad or a hernia was to explore it surgically. The fat pad was discovered and Dr. Movius testified that it was unique in his experience of 33 years of practice as a general surgeon.

[4] When a plaintiff produces evidence that is consistent with an hypothesis that the defendant is not negligent, and also with one that he is, his proof tends to establish neither. Schumacher v. Murray Hospital, 58 Mont. 447, 463, 193 P. 397.

[5] In the absence of a showing that the defendant acted without ordinary care, diligence and skill, or that he did not make a proper and skillful diagnosis, or that he deviated from established proper medical procedure as practiced in his neighborhood, we must uphold the trial court's directed verdict.

JAMES T. HARRISON, C. J., CASTLES and HASWELL, JJ., and LeROY L. McKINNON, District Judge [FN*], concur.

FN* Sitting for Justice JOHN W. BONNER.
Virginia Bakewell brought an action against Robert R. Kahle, a chiropractor, for malpractice. The Eleventh Judicial District Court, Flathead County, Dean King, J., rendered a judgment adverse to the defendant and the defendant appealed. The Supreme Court, Freebourn, J., held that the evidence made a case for jury.

Judgment affirmed.

West Headnotes

[1] Health 176
198Hk176 Most Cited Cases
(Formerly 299k6(1) Physicians and Surgeons)
"Chiropractic" is a system or the practice of adjusting the joints, especially of the spine, by hand for the curing of disease.

[2] Health 176
198Hk176 Most Cited Cases
(Formerly 299k6(1) Physicians and Surgeons)
A "chiropractor" is a practitioner of chiropractic.

[3] Health 690
198Hk690 Most Cited Cases
(Formerly 299k15(18) Physicians and Surgeons)
In malpractice action the law as applies to physicians, surgeons, dentists and the like applies to chiropractors.

[4] Health 637
198Hk637 Most Cited Cases
(Formerly 299k15(7) Physicians and Surgeons)
A fundamental duty of a physician is to make a properly skillful and careful diagnosis of ailment of a patient, and if he fails to bring to that diagnosis the proper degree of skill or care, and makes an incorrect diagnosis, he may be held liable to patient for damage thus caused just as readily as he must answer for application of improper treatment.

[5] Health 908
198Hk908 Most Cited Cases
(Formerly 299k15(15) Physicians and Surgeons)
While an unauthorized operation is, in contemplation of law, an assault and battery, it also amounts to malpractice, even though negligence is not charged.

198Hk623 Most Cited Cases
(Formerly 299k15(.5), 299k15 Physicians and Surgeons)
"Malpractice", also sometimes called "malapraxis" means bad or unskillful practice, resulting in injury to patient, and comprises all acts and omissions of physician or surgeon as such to a patient as such, which may make physician or surgeon either civilly or criminally liable.

[7] Health 825
198Hk825 Most Cited Cases
(Formerly 299k18.90, 299k18(9) Physicians and Surgeons)
In malpractice action against chiropractor, evidence that chiropractor told plaintiff that X-ray showed two misplaced vertebrae that could cause plaintiff's stiff neck, headache and sore spot behind right ear, and that plaintiff ordered defendant to quit thumping plaintiff on back of neck, and stated that plaintiff could not stand anymore, but that chiropractor gave plaintiff further adjustment, after which plaintiff could no longer walk, was in pain, suffered partial paralysis of throat and vocal chords, and suffered impaired vision, and that subsequent X-ray showed no vertebrae out of place, and evidence that plaintiff was suffering from brain tumor when plaintiff visited chiropractor, made a case for jury.

**127 *90 Rockwood & Sykes, Kalispell, for appellant.

Grant Bakewell, Moncure Cockrell, Kalispell, T. W. Greer, Whitefish, for respondent.

F. W. Wilson, Missoula, amicus curiae.
FREEBOURN, Justice.

Virginia Bakewell, plaintiff and respondent, brought this malpractice action against Robert R. Kahle, defendant and appellant, for damages, which she alleges she sustained as a patient of and at the hands of defendant, a licensed and practicing chiropractor.

From a jury verdict and judgment in favor of plaintiff in the amount of $5,000, defendant appeals.

Defendant gave plaintiff three treatments or adjustments of vertebrae in her neck, on April 4, 6, and 8, 1949, respectively. Prior to the first adjustment defendant took an x-ray picture of plaintiff's neck. He said such picture showed two vertebrae out of place, accounting for a stiff neck, headaches and sore spot behind the right ear, of which plaintiff complained. These adjustments were given to return such vertebrae to their proper position in the spine.

The complaint, among other things, alleged: That defendant wrongfully diagnosed and treated plaintiff for a misplaced vertebrae when she suffered a tumor or lesion of the brain; and 'the defendant was also negligent, careless and unskillful by giving the plaintiff a second and much harder thump on the 8th day of April, 1949, against plaintiff's will after he was told by her to stop, that she was sick and could not take any more.'

Plaintiff's testimony shows: 'A. Well, he explained the x-ray showed there were two vertebrae misplaced, and explained to me that could cause the condition which existed at that time in my head and neck, and I asked him what he would recommend as a cure, and he said adjustments would have to be made. I asked him if that would take long or be severe. He said, 'No, they aren't hard. This vertebra has probably been out of place for years, and it will take a while to get it back into place.'

As to what occurred during the April 8th adjustment she said:

'A. I was on the table long enough to get adjusted in the proper place. As soon as I was in the right position the thump came immediately, right away, by Dr. Kahle, on the sore spot on the back of the neck. *

'A. I said, 'Oh, that was awful.' I said, 'Something terrible has happened to me.' I said, 'That was awful.'
construed to be chiropractic except the application of the inherent qualities at the time in the patient or appertaining to the chiropractor.'

[1][2] It is 'a system, or the practice, of adjusting the joints, esp. *93 of the spine, by hand for the curing of disease.' A chiropractor is 'a practitioner of this system.' Merriam's Webster's New International Dictionary, sec. ed.

As a general rule, malpractice suits are based on negligence, and do not differ in **129 their essential ingredients from any other action for damages arising from negligence. 70 C.J.S., Physicians & Surgeons, § 48, p. 955.

[3] No good reason exists why, in such cases, the law, as applies to physicians, surgeons, dentists and the like, should not apply to chiropractors.

[4] It is one of the fundamental duties of a physician to make a properly skillful and careful diagnosis of the ailment of a patient, and if he fails to bring to that diagnosis the proper degree of skill or care, and makes an incorrect diagnosis, he may be held liable to the patient for the damage thus caused just as readily as he must answer for the application of improper treatment. 41 Am.Jur., Physicians and Surgeons, section, 92, p. 209. See 70 C.J.S., Physicians and Surgeons, § 48, pp. 960, 961.

[5][6] 'While an unauthorized operation is, in contemplation of law, an assault and battery, it also amounts to malpractice even though negligence is not charged. Herzog, Medical Jurisprudence, 153, § 180, defines malpractice as follows: 'Malpractice, also sometimes called 'malapraxis,' means bad or unskillful practice, resulting in injury to the patient, and comprises all acts and omissions of a physician or surgeon as such to a patient as such, which may make the physician or surgeon either civilly or criminally liable.' Physicians' and Dentists' Business Bureau v. Dray, 8 Wash.2d 38, 111 P.2d 568, 569. See 70 C.J.S., Physicians and Surgeons, § 40, p. 945, and 41 Am.Jur., Physicians and Surgeons, secs. 107, 108, pp. 220, 221.

Physicians and surgeons, called by plaintiff, competent to read x-ray pictures of the spine, after examining the x-ray picture of plaintiff's neck taken by defendant, stated such x-ray picture showed no vertebrae out of place.

*94 They also testified that other x-ray pictures of plaintiff's neck taken on April 8th, after she had reached the hospital, showed no vertebrae out of place.

The testimony of medical witnesses and evidence from the Mayo Clinic indicated plaintiff was suffering from a brain tumor when she visited defendant's office.

From the evidence before them, the jury could find: That defendant made a wrong diagnosis or analysis of plaintiff's condition, and that her stiff neck, headaches and sore spot behind the right ear were not due to vertebrae out of place; that there were no vertebrae out of place and the x-ray picture, taken by defendant, so showed; and that defendant should have given plaintiff no adjustment.

The jury could also find: That during the April 8th adjustment, after plaintiff directed defendant to stop, defendant continued adjustment and manipulation with his hands and caused a rupture of a brain tumor, resulting in injury to plaintiff.

One of plaintiff's witnesses, a physician and surgeon, testified, 'it was the trauma produced there was the cause,' of plaintiff's serious condition existing immediately after the April 8th adjustment.


The verdict was not excessive.

We have examined all errors assigned by appellant and find none which affect the substantial rights of the parties.

For the reasons stated the judgment of the lower court is affirmed.

ADAIR, C. J., and METCALF, BOTTOMLY and ANGSTMAN, JJ., concur.

125 Mont. 89, 232 P.2d 127

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Presently before the Court is Plaintiff’s motion for summary judgment. The motion has been fully briefed and is submitted for decision.

The chronology of this case has been set forth in an earlier ruling and need not be repeated here. This lawsuit challenges the constitutionality of the Parental Notice of Abortion Act (the Act), Sections 50-20-201 to 215, MCA. A preliminary injunction was issued by this Court on February 13, 1998, enjoining the enforcement of the Act pending final resolution of the issues raised in the complaint.

Plaintiffs have moved for summary judgment on the ground that the Act violates Montana’s constitutional guarantee of equal protection, Article II, Section 4, Montana Constitution. The motion and briefs are supported by affidavits, depositions, published articles and other discovery materials.

**Legal Standard**


Summary judgment, however, will only be granted when the record discloses no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. See Rule 56(c), M.R.Civ.P.; *Cute v. Hargrave*, 209 Mont. 265, 269, 680 P.2d 952, 954 (1984).

**Equal Protection under the Montana Constitution**


The United States District Court has upheld Montana’s parental notification statute under the United States Constitution’s Equal Protection Clause. However, a statute, even though constitutional under the federal constitution, is not necessarily constitutional under analogous provisions of a state constitution, which may be interpreted by the state courts to provide heightened and expanded rights. *Butte Community Union v. Lewis*, 219 Mont. 426, 433, 712 P.2d 1309, 1313 (1986).

Analysis of constitutionality of legislation under an equal protection challenge requires the court to review the legislation under one of three recognized levels of scrutiny. The “strict scrutiny” standard, the highest level of scrutiny, is used when an action complained of infringes upon the exercise of a fundamental right or discriminates against a suspect class. *Davis*, 282 Mont. at 241, 937 P.2d at 31, citing *Gulbranson v. Carey*, 272 Mont. 494, 502, 901 P.2d 572, 579 (1995). Strict scrutiny requires the government to show a compelling state interest for its action. *Id.*, citing *Butte Community Union*, 219 Mont. at 430, 712 P.2d at 1311.

The next level of scrutiny is used in limited situations, such as where the rights at issue have some origin in the Montana constitution, but are not found in the Declaration of Rights. This middle tier of scrutiny requires the state to demonstrate that its classification is reasonable and that its interest in the classification is greater than that of the individual’s...
interest in the right infringed.  *Id.*, at 241, 937 P.2d at 31-32.

The lowest level of scrutiny is applicable to examination of rights not determined to be fundamental under the Montana constitution, and not worthy of middle tier scrutiny. This test requires the government to show that the objective of the statute is legitimate and bears a rational relationship to the classification used by the legislature.  *Id.*, citing *Cottrill v. Cottrill Sodding Service*, 229 Mont. 40, 43, 744 P.2d 895, 897 (1987).

**Applying Equal Protection Analysis to this Case**

The first step in this analysis is to identify the classes involved and determine whether they are similarly situated.  *In re C.H.*, 210 Mont. 184, 198, 683 P.2d 931, 938 (1984).  Plaintiffs assert that the Act creates a class of pregnant minors who want to obtain an abortion and a class of pregnant minors who do want an abortion. For purposes of equal protection analysis, both of these classes are composed of persons who are similarly situated, i.e., minors who are pregnant.

The next step is to determine whether a suspect classification is involved.  *Id.*  A suspect class is one “saddled with such disabilities, or subjected to such a history of purposeful unequal treatment, or relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process.  *Id.*, citing *San Antonio Sch. Dist. V. Rodriguez*, 411 U.S. 1, 28 (1973).  The class of minor pregnant women is not a suspect class.

The next step is to determine whether the individual interest affected is a fundamental right, triggering a strict scrutiny analysis.  *In re S.L.M.*, 287 Mont. 23, 33, 951 P.2d 1365, 1371 (1997).  This question is resolved by the Montana Constitution itself.  Article II, Section 10, entitled Rights of Persons Not Adults, provides: “The rights of persons under 18 years of age shall include, but not be limited to, all the fundamental rights of this Article unless specifically precluded by laws which enhance the protection of such persons.”

Thus, minors, including pregnant minors, have a fundamental right of individual privacy that includes personal-autonomy privacy, and, as this Court previously ruled in its order granting preliminary injunction, the constitutional right of privacy encompasses a woman’s right to decide whether to terminate her pregnancy.

The next question is whether the challenged legislation infringes pregnant minors’ rights to privacy.

Plaintiffs assert that the Act invades the privacy rights of those minors who want to obtain an abortion. Defendants contend that it does not. The Court has been provided with much evidence concerning adolescent women faced with the consideration of abortion. That evidence provides undisputed facts material to the issue of whether pregnant minors who want to obtain an abortion are infringed of their privacy rights by the Act.

With respect to pregnant women in general, some refuse to tell their partner or parents about the pregnancy and/or decision to have an abortion because of their fear of disapproval. Nancy E. Adler, *Abortion: A Social-Psychological Perspective*, 35 J. Social Issues 100, 104 (1979).

The younger the minor, the more likely it is that she will involve her parents. Minors who chose not to tell their parents about their pregnancy tended to be more financially independent and more likely to live alone. Minors who chose not to tell their parents about their pregnancy often had good reason for doing so. Nancy E. Adler, et al., *Abortion among Adolescents, in The New Civil War* 285, 290 (Linda J. Beckman & S. Marie Harvey eds., 1998). In a study by Stanley K. Henshaw and Kathryn Kost, 30 percent of the young women who did not tell their parents had experienced domestic violence, feared it would occur, or were fearful of being forced to leave home. Sometimes the pregnancy is the result of incest, making it difficult, impractical or dangerous for the parents to know about the pregnancy. Stanley K. Henshaw and Kathryn Kost, *Parental Involvement in Minors’ Abortion Decisions*, 24 Family Planning Perspectives 196 (1992).
are often accurate in their prediction of their parents’ reactions. (Henshaw Aff.)

In that same study, 39 percent of minors who had an abortion did not tell a parent. The vast majority of these women were older adolescents, many of whom were independent in various respects: they were employed, living apart from parents, already had a child, or had previously had an abortion. A study by Henshaw and Kost revealed that very few women under the age of 15 did not tell a parent about the pregnancy. Henshaw and Kost, supra, at 200. Minors who did not obtain parental involvement all had discussions with friends, relatives or others not a parent. Id.; Adler, Abortion among Adolescents, supra, at 291.

Older adolescents are more concerned with protecting their privacy and thus are less likely to desire parental involvement. Immature minors, on the other hand, are often more financially and emotionally dependent on their parents. As a result, they are more inclined to seek their parents’ advice and support. Adler, Abortion among Adolescents, supra, at 291-92.

In one study, pressure from parents finding out about the pregnancy against the minor’s wishes and from a source other than the minor had significant consequences. Eighteen percent of the minors were forced or pressured by the parent to have an abortion against the minors’ wishes, and another six percent reported other serious consequences such as physical violence or being forced from the home. Henshaw and Kost, Parental Involvement in Minors’ Abortion Decisions, supra; Henshaw Aff.

The intended effects of parental notification/consent laws and judicial bypass requirements are to assure adequate guidance of adolescents and to promote parental involvement, but they have negative consequences as well. Adolescents who fear telling their parents, and who may have a basis for concern about their parents’ response, may not feel comfortable in trying to obtain a judicial bypass of the consent/notification laws. They may be intimidated by the court system and may not know how to go about obtaining legal approval. Adler, Abortion among Adolescents, supra, at 293. Minors have significant difficulties in arranging for the judicial bypass. For example, they may not have an opportunity for a confidential telephone conversation. Additionally, these women may have no access to a private phone for return calls pertaining to the bypass procedure. Many minors still live at home and go to school. The bypass procedure places additional burdens on them to arrange legitimate excuses from school and home, while maintaining privacy and confidentiality. Many of these women have no transportation to and from court, and those who can arrange rides, may have to do so through a parent or friend of the family, jeopardizing the privacy of the minor. Many adolescents are not acquainted with the location of the courthouse, or with the procedures involved. While attempting to defend and maintain their privacy, they are compelled to tell their stories to the judge, a stranger. Some of the women fear breach of confidence in smaller communities, where court personnel may know their families. Adler, Abortion among Adolescents, supra, at 293; Jamie Sabino Aff.

Based on this information, the Court finds that the Act infringes on the privacy rights of pregnant minors who wish to terminate their pregnancies.

The next step is the determination of whether there is a compelling state interest sufficient to justify the Act’s infringement on the class’ fundamental right to privacy. Davis, 282 Mont. at 241, 937 P.2d at 31; In re C.H., 210 Mont. at 198, 693 P.2d at 938.

The Act itself declares what the compelling state interests are:

(a) protecting minors against their own immaturity;

(b) fostering family unity and preserving the family as a viable social unit;

(c) protecting the constitutional rights of parents to rear children who are members of their household; and

(d) reducing teenage pregnancy and unnecessary abortion.

Section 50-20-2002(2), MCA.

With respect to subsections (a) and (b), the following undisputed facts, in addition to those already described above, are material.

The literature addressing adolescents and abortion includes studies involving parental consent laws as well as parental notification laws. Both have the same effect on pregnant minors. (Sabino Aff.)
Medical risks for abortion in the first trimester are low. Mortality risks are 20 times greater for pregnancy and childbirth than for abortion for women 15 to 19 years of age. Adler, *Abortion among Adolescents*, supra, at 286; Mark Miles Aff.

There is little basis for the assertion that abortion leads to severe psychological consequences among women in the general population. Research directly focused on adolescents does not show them to be particularly vulnerable to serious negative responses following abortion. Studies, including those by the American Psychological Association, have concluded that legal abortion of an unwanted pregnancy in the first trimester does not pose a psychological hazard for most women. Adler, *Abortion among Adolescents*, supra, at 286. Studies following adolescents one and two years post-abortion found no substantial psychological effects, and even found the abortion to have been a positive experience in some of the women. Id. at 287. A study of African-American adolescents under the age of 17 indicated low rates of psychological effects on those who obtained abortions when compared to those who received negative pregnancy test results and those who carried their pregnancy to term. That study found negative psychological effects related to subsequent pregnancies in the women, and that the women who had obtained abortions had the lowest rates of subsequent pregnancy. The women who had abortions also fared better economically, emotionally and educationally than the other women in the study. Id.; Nancy E. Adler et al., *Psychological Responses after Abortion*, 248 Science 41 (1990).

Abortion is generally experienced as a stressful event. Much of the stress is associated with the discovery and acknowledgment of an unwanted pregnancy and the need for a decision about whether to continue or terminate it. Women generally report that the greatest distress is between the discovery that they are pregnant and the abortion. Thus, evaluations of psychological stress must be viewed as caused by the pregnancy itself as well as the abortion. Adler, *Abortion: A Social-Psychological Perspective*, supra, at 112. Immediate post-abortion responses were more positive when there was greater social support for the abortion, suggesting that one source of stress on the woman is known or anticipated disapproval of partners or parents. The social climate, disdaining abortion, contributes significantly to the stress on the woman in addition to the process of abortion itself. Many women choose not to tell their partner or parents about the pregnancy and intention to have an abortion because of the fear of disapproval. Id., at 104.

The studies addressed in Adler’s articles indicate that adolescents do not seem to be at a substantial risk of negative psychological responses up to two years following abortion; that adolescents who had abortions compared with those who either carried to term and those who discovered that they were not pregnant, showed a more favorable psychological profile over time; and that there were no measurable differences in psychological responses among women under 18 compared to those 18 to 21. The studies provide no compelling rationale for restrictive legislation for adolescents based on their degree of risk of adverse effects.

Studies reveal that the younger the adolescent, the more likely it is that she will involve her parents in her decision about an abortion. Adolescents who do not tell their parents tend to be older than the ones who do. More mature adolescents are more concerned with protecting their privacy, and thus are less likely to desire parental involvement. Immature minors, on the other hand, are often more financially and emotionally dependent on their parents. Thus, they are more inclined to seek their parents’ advice and support. Adler, *Abortion among Adolescents*, supra, at 291-92.

Adolescents who choose not to tell their parents about their pregnancy often have good reasons for doing so. They are often accurate in their predictions of their parents’ reactions. (Henshaw Aff.)

Judicial bypass procedures accomplish little, if any, protection for adolescents, primarily because virtually all requests for judicial bypass are granted. Adler, *Abortion among Adolescents*, supra, at 293. In Massachusetts, for example, 98 percent of judicial bypasses have been granted. Those women who were forced to experience the judicial bypass procedure were subjected to needless stress, anxiety, delay and breaches of confidentiality. (Sabino Aff.; Henshaw Aff.)

The judicial bypass procedure poses additional health risks to adolescents by causing added delays in obtaining an abortion. Minors tend to seek abortions later in the pregnancy than do adults. A greater percentage of minors than adults have abortions after the first trimester. Adler, *Abortion among Adolescents*, supra, at 293; Henshaw Aff. Such delays are due to a variety of reasons, including the fact that the minors may not be aware of pregnancy.
symptoms as readily as adults are, they may have more difficulty arranging for pregnancy tests and abortions, and they may simply be less willing to acknowledge their pregnancy for many weeks. When judicial bypass is added, more minors may get pushed into second trimester abortions. Adler, Abortion among Adolescents, supra, at 293. In addition, those women who make arrangements to go out of state for an abortion to avoid parental notification or consent requirements are delayed in obtaining abortions, sometimes beyond the first trimester. Id.

The added risks of a delayed abortion and the experience of judicial bypass may themselves be stressful and anxiety provoking for minors. Id. Studies indicate no evidence that adolescents are incompetent in their decision-making to have an abortion, although their decision-making may be based on different biases from those generally possessed by adults. Id., at 292-93. Although there are conflicting findings concerning whether younger adolescents are less capable than older adolescents of competent reasoning in general, in the specific domain of reasoning about abortion, findings are more consistent and show little evidence that adolescents lack the capacity to reason effectively about this decision. In studies comparing adolescent women with adult women, there were no significant differences between adolescents and adults in their hypothetical reasoning about abortion, and no differences in reasoning when the studies conducted assessments of legal competence. Adolescents in every age group were as competent as adults in considering abortion. Id., at 290-93.

In Massachusetts, there is no evidence that parental consent/notification laws have increased the rate of parental involvement or enhanced minors’ decision-making processes. The laws have driven many minors to leave the state to obtain abortions. (Sabino Aff.)

With respect to subsection (d) of the Act’s compelling state interests, “reducing teenage pregnancy and unnecessary abortion,” the following undisputed facts are material.

Studies found an increase in late abortions and in out-of-state abortions in Missouri after the enactment of parental consent/notification laws in the state, although similar studies in Minnesota were less clear. The study focused on first trimester abortions, and any decrease in first trimester abortions in Minnesota may have been the result of more second trimester abortions, caused by delay from the laws. Adler, Abortion among Adolescents, supra, at 294. Women who make arrangements to go out of state for an abortion to avoid those laws may also be delayed in obtaining an abortion. Id.

In Massachusetts, the parental consent/notification laws have driven many minors out of state to obtain abortions, but the abortion rate has remained the same. (Sabino Aff.) The parental consent laws in Mississippi have had little or no effect on the abortion rate in that state. (Henshaw Aff.) Statistics provided by the Defendants with respect to the effect of consent and notification statutes in other states indicated no significant changes in abortion rates. Montana is particularly difficult in availability of abortion providers. Thirty percent of women seeking abortions have to travel at least 100 miles, due to geographical distances and scarcity of abortion providers. Burdens on adolescents are much greater than on adults for traveling such distances. (Henshaw Aff.) The added burdens on these minors create greater risks of delayed abortions and consequential medical problems.

With respect to the Act’s compelling state interest of “protecting the constitutional rights of parents to rear children who are members of their household,” when the Court balances the fundamental privacy right of the minor against the rights of the parents that are allegedly enhanced by the Act, the right of privacy prevails over the unsubstantiated rights claimed to be enhanced by the Act. As previously noted, the undisputed evidence before this Court indicates that the majority of pregnant minors involve a parent in decision-making about whether to obtain an abortion, and those minors who do not involve their parents often have a legitimate reason for not doing so. In those cases involvement is not in the minors’ best interests.

The last step of the analysis is to determine whether the Act complies with the mandates of Article II, Section 15, of the Montana Constitution, which allows the legislature to limit the fundamental rights of minors, if the exception enhances the protection of such minors. In re S.L.M., 287 Mont. at 21-22, 951 P.2d at 1372-73.

In addition to stating compelling state interest, the Act also provides a statement of purpose:
(a) immature minors lack the ability to make fully informed choices that take into account both immediate and long-range consequences;

(b) the medical, emotional, and psychological consequences of abortion are sometimes serious and can be lasting, particularly when the patient is immature;

(c) the capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion are not necessarily related;

(d) parents ordinarily possess information essential to a physician in the exercise of the physician’s best medical judgment concerning the minor;

(e) parents who are aware that their minor daughter has had an abortion may better ensure that the daughter receives adequate medical care after the abortion; and

(f) parental consultation is usually desirable and in the best interest of the minor.

Section 50-20-202(1), MCA.

The undisputed evidence contradicts the compelling state interest and statements of purpose expressed in the Act. As discussed above, studies show that adolescents are as competent as adults in considering abortion. Medical risks for abortion are considerably lower than for pregnancy and childbirth, and, in general, adolescents show no substantial psychological effects from abortion. In fact, the consequences of deciding to continue the pregnancy can be considerably greater than of terminating it. Adolescent mothers are particularly vulnerable to severe and adverse social and economic consequences of bearing and raising children. Many do not complete high school and end up in poverty and on welfare. Children of adolescents are more likely to be born prematurely and to be of low birth weight, increasing their risk of health problems. (Henshaw Aff.) Most pregnant minors do consult a parent about the decision, and those who did not obtain parental involvement did have discussions with friends or relatives. For those minors who choose not to tell a parent about their decision to obtain an abortion, the judicial bypass procedure provides little, if any, protection and, in fact, increases stress, delay and potential medical complications. The Court concludes that the Act does not enhance the protection of minors.

Moreover, the Act’s stated interests and purposes create unequal and unfair application to pregnant minors who want to terminate their pregnancy, when compared with the class of pregnant minors who choose not to do so. Minors can obtain contraception without parental involvement. Minors who choose to continue their pregnancy are free to do so without any requirement of parental notification. They can obtain any medical treatment, including surgical procedures, for the pregnancy, for the birth, and for the baby without being required to notify their parent(s). Section 41-1-402, 403, MCA. They can relinquish their babies for adoption without having to notify their parent(s). Section 42-2-405, MCA. Nor are there any legal requirements for minors to involve their parents in the care and rearing of their children.

Thus, the minor who is presumed by the Act to be too immature to decide to have an abortion will, if she continues her pregnancy, become the mother of an infant, fully responsible for its life and for decisions about its medical and other care, without statutory requirements for parental involvement.

Based on the undisputed material facts presented, the Court concludes that the Defendants have not shown a compelling state interest in requiring parental notification of a minor’s intent to terminate her pregnancy. Furthermore, the Act does not enhance the protection of minors. Plaintiffs are entitled to judgment as a matter of law on the issue of the Montana constitutional guarantee of equal protection.

Summary judgment is GRANTED to Plaintiffs in accordance with this decision.

Let judgment be entered accordingly.

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Supreme Court of the United States
Kelly A. AYOTTE, Attorney General of New Hampshire, petitioner, v. PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, et al. - 125 S.Ct. 2294 (Mem), 161 L.Ed.2d 1088, 73 USLW 3531, 73 USLW 3681, 73 USLW 3684
No. 04-1144.


Holding: The Supreme Court, Justice O'Connor, held that constitutional challenge to New Hampshire's parental notification law, as not containing exception to allow minor to obtain abortion without notice to her parent when necessary to preserve minor's health, would be remanded to the Court of Appeals for determination as to whether, upon finding that law could be applied in manner that violated minor's constitutional rights, court could not, in manner consistent with legislative intent, devise narrower remedy than permanent injunction against enforcement of law in its entirety.

Vacated and remanded.

West Headnotes

Abortion and Birth Control 4 117

States, based on their strong and legitimate interest in welfare of their young citizens, whose immaturity, inexperience and lack of judgment may sometimes impair their ability to exercise their rights wisely, may require parental involvement when minor considers terminating her pregnancy.

Abortion and Birth Control 4 108

States may not restrict access to abortions that are necessary, in appropriate medical judgment, for preservation of life or health of mother.

Declaratory Judgment 118A 124.1

When court is faced with statute restricting access to abortions that may be applied in unconstitutional manner so as to harm mother's health, necessary and appropriate remedy is not always to invalidate statute in its entirety; court may be able to render narrower declaratory and injunctive relief.

Injunction 212 \(\Rightarrow\) 85(2)

212 Injunction
212II Subjects of Protection and Relief
212II(E) Public Officers and Entities
212k85 Enforcement of Statutes, Ordinances, or Other Regulations
212k85(2) k. On Ground of Invalidity.

Most Cited Cases

Statutes 361 \(\Rightarrow\) 64(1)

361 Statutes
361I Enactment, Requisites, and Validity in General
361k64 Effect of Partial Invalidity
361k64(1) k. In General, Most Cited Cases

Generally, when confronting a constitutional flaw in statute, Supreme Court tries to limit the solution to the problem, and prefers to enjoin only the unconstitutional applications of statute while leaving other applications in force, or to sever its problematic portions while leaving the remainder intact.

Constitutional Law 92 \(\Rightarrow\) 2478

92 Constitutional Law
92XX Separation of Powers
92XX(C) Judicial Powers and Functions
92XX(C)2 Encroachment on Legislature
92k2478 k. Invalidation, Annulment, or Repeal of Statutes, Most Cited Cases
(Formerly 92k70.1(3))

When confronting a constitutional flaw in statute, Supreme Court tries not to nullify more of legislature's work than is necessary, on theory that a ruling of unconstitutionality frustrates intent of the people's elected representatives.

Constitutional Law 92 \(\Rightarrow\) 657

92 Constitutional Law
92V Construction and Operation of Constitutional Provisions
92V(F) Constitutionality of Statutory Provisions
92k657 k. Invalidity as Applied, Most Cited Cases
(Formerly 92k38)

Statute may be constitutionally invalid as applied to one state of facts and yet valid as applied to another.

Constitutional Law 92 \(\Rightarrow\) 2473

92 Constitutional Law
92XX Separation of Powers
92XX(C) Judicial Powers and Functions
92XX(C)2 Encroachment on Legislature
92k2472 Making, Interpretation, and Application of Statutes
92k2473 k. In General, Most Cited Cases
(Formerly 92k70.1(2))

Touchstone for any decision about appropriate remedy for constitutional flaw in statute is legislative intent, as court cannot use its remedial powers to circumvent intent of legislature.

Statutes 361 \(\Rightarrow\) 64(1)

361 Statutes
361I Enactment, Requisites, and Validity in General
361k64 Effect of Partial Invalidity
361k64(1) k. In General, Most Cited Cases

Normal rule for court, when confronting a constitutional flaw in statute, is that partial, rather than facial, invalidation is required course, so that statute may be declared invalid only to extent that it reaches too far.

Constitutional Law 92 \(\Rightarrow\) 1026

92 Constitutional Law
92VI Enforcement of Constitutional Provisions
92VI(C) Determination of Constitutional Questions
92VI(C)3 Presumptions and Construction as to Constitutionality
92k1024 Limitations of Rules and Special Circumstances Affecting Them
92k1026 k. Rewriting to Save from Unconstitutionality, Most Cited Cases
(Formerly 92k48(8))

Mindful of its limited constitutional mandate and institutional competence, Supreme Court restrains itself from rewriting state law to conform to constitutional requirements, even as it strives to salvage it from constitutional challenge.

Constitutional Law 92 \(\Rightarrow\) 2473

92 Constitutional Law
92XX Separation of Powers
92XX(C) Judicial Powers and Functions
92XX(C)2 Encroachment on Legislature
92k2472 Making, Interpretation, and Application of Statutes
92k2473 k. In General, Most Cited Cases
(Formerly 92k70.1(2))

Touchstone for any decision about appropriate remedy for constitutional flaw in statute is legislative intent, as court cannot use its remedial powers to circumvent intent of legislature.

Statutes 361 \(\Rightarrow\) 64(1)

361 Statutes
361I Enactment, Requisites, and Validity in General
361k64 Effect of Partial Invalidity
361k64(1) k. In General, Most Cited Cases

To determine appropriate remedy for constitutional flaw in statute, court, after finding that an application
or portion of statute is unconstitutional, must next inquire whether the legislature would have preferred what is left of statute to no statute at all.

**[11]** Abortion and Birth Control 4 ☞ 123

4 Abortion and Birth Control

4k116 Substitution and Bypass; Notice

4k123 k. Proceedings. Most Cited Cases

(Formerly 4k1.30)

Federal Courts 170B ☞ 947

170B Federal Courts

170BVIII Courts of Appeals

170BVIII(L) Determination and Disposition of Cause

170Bk943 Ordering New Trial or Other Proceeding

170Bk947 k. Further Evidence, Findings or Conclusions. Most Cited Cases

Constitutional challenge to New Hampshire's parental notification law, as not containing exception to allow minor to obtain abortion without notice to her parent when necessary to preserve minor's health, would be remanded to the Court of Appeals for determination as to whether, upon finding that law could be applied in manner that violated minor's constitutional rights, court could not, in manner consistent with legislative intent, devise narrower remedy than permanent injunction against enforcement of this parental notification law in its entirety. N.H.RSA 132:24, 132:25, 132:26, 132:27, 132:28

West Codenotes


**962*320SyllabusFN**

FN* The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See United States v. Detroit Timber & Lumber Co., 200 U.S. 321, 337, 26 S.Ct. 282, 50 L.Ed. 499.

New Hampshire's Parental Notification Prior to Abortion Act, in relevant part, prohibits physicians from performing an abortion on a pregnant minor until 48 hours after written notice of such abortion is delivered to her parent or guardian. The Act does not require notice for an abortion necessary to prevent the minor's death if there is insufficient time to provide notice, and permits a minor to petition a judge to authorize her physician to perform an abortion without parental notification. The Act does not explicitly permit a physician to perform an abortion in a medical emergency without parental notification. Respondents, who provide abortions for pregnant minors and expect to provide emergency abortions for them in the future, filed suit under Rev.Stat. § 1979, 42 U.S.C. § 1983, claiming that the Act is unconstitutional because it lacks a health exception and because of the inadequacy of the life exception and the judicial bypass confidentiality provision. The District Court declared the Act unconstitutional and permanently enjoined its enforcement, and the First Circuit affirmed.

Held: If enforcing a statute that regulates access to abortion would be unconstitutional in medical emergencies, invalidating the statute entirely is not always necessary or justified, for lower courts may be able to render narrower declaratory and injunctive relief. Pp. 966-969.

(a) As the case comes to this Court, three propositions are established. First, States have the right to require parental involvement when a minor considers terminating her pregnancy. Second, a State may not restrict access to abortions that are "necessary, in appropriate medical judgment for preservation of the life or health of the mother." Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 879, 112 S.Ct. 2791, 120 L.Ed.2d 674 (plurality opinion). Third, New Hampshire has not taken issue with the case's factual basis: In a very small percentage of cases, pregnant minors need immediate abortions to avert serious and often irreversible damage to their health. New Hampshire has conceded that, under this Court's cases, it would be unconstitutional to apply the Act in a manner that subjects minors to significant health risks. Pp. 966-967.

*321 b) Generally speaking, when confronting a statute's constitutional flaw, this Court tries to limit the solution to the problem, preferring to enjoin only the statute's unconstitutional applications while leaving the others in force, see United States v. Raines, 362 U.S. 17, 20-22, 80 S.Ct. 519, 4 L.Ed.2d 524, or to sever its problematic portions while leaving the remainder intact, United States v. Booker, 543 U.S. 220, 227-229, 125 S.Ct. 738, 160 L.Ed.2d 621. Three interrelated principles inform the Court’s approach to remedies. First, the Court tries not to nullify more of a legislature's work than is necessary. Second, mindful that its constitutional mandate and institutional competence are limited, the Court restrains itself from “rewrit[ing] state law to conform
it to constitutional requirements.” *Virginia v. American Booksellers Assn., Inc.*, 484 U.S. 383, 397, 108 S.Ct. 636, 98 L.Ed.2d 782. Third, the touchstone for any decision about remedy is legislative intent. After finding an application or portion of a statute unconstitutional, the Court must ask: Would the legislature have preferred what is left of its statute to no statute at all? See generally, e.g., *Booker*, *supra*, at 227, 125 S.Ct. 738. Here, the courts below chose the most blunt remedy-permanently enjoining the Act's enforcement and thereby invalidating it entirely. They need not have done so. In *Stenberg v. Carhart*, 530 U.S. 914, 120 S.Ct. 2597, 147 L.Ed.2d 743—where this Court invalidated Nebraska's “partial birth abortion” law in its entirety for lacking a health exception—the parties did not ask for, and this Court did not contemplate, relief more finely drawn, but here New Hampshire asked for and respondents recognized the possibility of a more modest remedy. Only a few applications of the Act would present a constitutional problem. So long as they are faithful to legislative intent, then, in this case the lower courts can issue a declaratory judgment and an injunction prohibiting the Act's unconstitutional application. On remand, they should determine in the first instance whether the legislature intended the statute**964 to be susceptible to such a remedy. Pp. 967-969.

(c) Because an injunction prohibiting unconstitutional applications or a holding that consistency with legislative intent requires invalidating the statute *in toto* should obviate any concern about the Act's life exception, this Court need not pass on the lower courts' alternative holding. If the Act survives in part on remand, the Court of Appeals should address respondents' separate objection to the judicial bypass' confidentiality provision. P. 969.

390 F.3d 53, vacated and remanded.

O'CONNOR, J., delivered the opinion for a unanimous Court.

Paul D. Clement, for the United States as amicus curiae, by special leave of the Court, supporting the petitioner.


Justice O'CONNOR delivered the opinion of the Court.

*323 We do not revisit our abortion precedents today, but rather address a question of remedy: If enforcing a statute that regulates access to abortion would be unconstitutional in medical emergencies, what is the appropriate judicial response? We hold that invalidating the statute entirely is not always necessary or justified, for lower courts may be able to render narrower declaratory and injunctive relief.

I

A

In 2003, New Hampshire enacted the Parental Notification Prior to Abortion Act. N.H.Rev.Stat. Ann. §§ 132:24-132:28 (2005). The Act prohibits physicians from performing an abortion on a pregnant minor (or a woman for whom a guardian or conservator has been appointed) until 48 hours after written notice of the pending abortion is delivered *324 to her parent or guardian. § 132:25(I). Notice may be delivered personally or by certified mail. §§ 132:25(II), (III). Violations of the Act are subject to criminal and civil penalties. § 132:27.

The Act allows for three circumstances in which a physician may perform an abortion without notifying the minor's parent. First, notice is not required if “[t]he attending abortion provider certifies in the pregnant minor's record that the abortion is necessary to prevent the minor's death and there is insufficient time to provide **965 the required notice.” § 132:26(I)(a). Second, a person entitled to receive notice may certify that he or she has already been notified. § 132:26(I)(b). Finally, a minor may petition a judge to authorize her physician to perform an abortion without parental notification. The judge...
must so authorize if he or she finds that the minor is mature and capable of giving informed consent, or that an abortion without notification is in the minor’s best interests. § 132:26(II). These judicial bypass proceedings “shall be confidential and shall be given precedence over other pending matters so that the court may reach a decision promptly and without delay,” and access to the courts “shall be afforded [to the] pregnant minor 24 hours a day, 7 days a week.” §§ 132:26(II)(b), (c). The trial and appellate courts must each rule on bypass petitions within seven days. Ibid.

The Act does not explicitly permit a physician to perform an abortion in a medical emergency without parental notification.

B

Respondents are Dr. Wayne Goldner, an obstetrician and gynecologist who has a private practice in Manchester, and three clinics that offer reproductive health services. All provide abortions for pregnant minors, and each anticipates having to provide emergency abortions for minors in the future. Before the Act took effect, respondents brought suit under 42 U.S.C. § 1983, alleging that the Act is unconstitutional*325 because it fails “to allow a physician to provide a prompt abortion to a minor whose health would be endangered” by delays inherent in the Act. App. 10 (Complaint, ¶ 24). Respondents also challenged the adequacy of the Act’s life exception and of the judicial bypass’ confidentiality provision.

The District Court declared the Act unconstitutional, see 28 U.S.C. § 2201(a), and permanently enjoined its enforcement. It held, first, that the Act was invalid for failure “on its face [to] comply with the constitutional requirement that laws restricting a woman’s access to abortion must provide a health exception.” Planned Parenthood of Northern New Eng. v. Heed, 296 F.Supp.2d 59, 65 (D.N.H.2003). It also found that the Act’s judicial bypass would not operate expeditiously enough in medical emergencies. In the alternative, the District Court held the Act’s life exception unconstitutional because it requires physicians to certify with impossible precision that an abortion is “necessary” to avoid death, and fails to protect their good faith medical judgment.

The Court of Appeals for the First Circuit affirmed. Citing our decisions in Stenberg v. Carhart, 530 U.S. 914, 929-930, 120 S.Ct. 2597, 147 L.Ed.2d 743 (2000), Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 879, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992) (plurality opinion), and Roe v. Wade, 410 U.S. 113, 164-165, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973), it observed: “Complementing the general undue burden standard [for reviewing abortion regulations], the Supreme Court has also identified a specific and independent constitutional requirement that an abortion regulation must contain an exception for the preservation of the pregnant woman’s health.” Planned Parenthood of Northern New Eng. v. Heed, 390 F.3d 53, 58 (2004). It went on to conclude that the Act is unconstitutional because it does not contain an explicit health exception, and its judicial bypass, along with other provisions of state law, is no substitute. The Court of Appeals further found the Act unconstitutional because, in its view, the life exception forces physicians to gamble with their patients’ *326 lives by prohibiting them from performing an abortion without notification **966 until they are certain that death is imminent, and is intolerably vague. Because the district and appellate courts permanently enjoined the Act’s enforcement on the basis of the above infirmities, neither reached respondents’ objection to the judicial bypass’ confidentiality provision.

We granted certiorari, 544 U.S. 1048, 125 S.Ct. 2294, 161 L.Ed.2d 1088 (2005), to decide whether the courts below erred in invalidating the Act in its entirety because it lacks an exception for the preservation of pregnant minors’ health. We now vacate and remand for the Court of Appeals to reconsider its choice of remedy.

II

[1] As the case comes to us, three propositions—two legal and one factual—are established. First, States unquestionably have the right to require parental involvement when a minor considers terminating her pregnancy, because of their “strong and legitimate interest in the welfare of [their] young citizens, whose immaturity, inexperience, and lack of judgment may sometimes impair their ability to exercise their rights wisely.” Hodgson v. Minnesota, 497 U.S. 417, 444-445, 110 S.Ct. 2926, 111 L.Ed.2d 344 (1990) (opinion of STEVENS, J.). FN1 Accordingly, we have *327 long upheld state parental involvement statutes like the Act before us, and we cast no doubt on those holdings today. See, e.g., Lambert v. Wicklund, 520 U.S. 292, 117 S.Ct. 1169, 137 L.Ed.2d 464 (1997)(per curiam); Casey.http://www.westlaw.com/Find/Default.wl?rs=dfa1.0&vr=2.0&DB=708&FindType=Y&S
ialNum=199216314supra, at 899, 112 S.Ct. 2791
(joint opinion); Ohio v. Akron Center for Reproductive Health, 497 U.S. 502, 510-519, 110 S.Ct. 2972, 111 L.Ed.2d 405 (1990); *Hodgson, 497 U.S., at 461, 110 S.Ct. 2926 (O'CONNOR, J., concurring in part and concurring in judgment in part); id., at 497-501, 110 S.Ct. 2926 (KENNEDY, J., concurring in judgment in part and dissenting in part).18


FN2. It is the sad reality, however, that young women sometimes lack a loving and supportive parent capable of aiding them “to exercise their rights wisely.” *Hodgson, 497 U.S., at 444, 110 S.Ct. 2926 (opinion of STEVENS, J.); see *id., at 450-451, and n. 36, 110 S.Ct. 2926 (opinion of the Court) (holding unconstitutional a statute requiring notification of both parents, and observing that “the most common reason” young women did not notify a second parent was that the second parent “was a child-spouse-batterer, and notification would have provoked further abuse” (citation omitted)). See also Department of Health and Human Services, Administration on Children, Youth and Families, Child Maltreatment 2003, p. 63 (2005) (parents were the perpetrators in 79.7% of cases of reported abuse or neglect).


Third, New Hampshire has not taken real issue with the factual basis of this litigation: In some very small percentage of cases, pregnant minors, like adult women, need immediate abortions to avert serious
and often irreversible damage to their health. See 296 F.Supp.2d, at 65, n. 4.

New Hampshire has maintained that in most if not all cases, the Act’s judicial bypass and the State’s “competing harms” statutes should protect both physician and patient when a minor needs an immediate abortion. See N.H.Rev.Stat. Ann. § 627:3(I) (1996) (for criminal liability, “[c]onduct which the actor believes to be necessary to avoid harm to ... another is justifiable if the desirability and urgency of avoiding such harm outweigh, according to ordinary standards of reasonableness, the harm sought to be prevented by the statute defining the offense charged”); § 627:1 (similar for civil liability). But the District Court and Court of Appeals found neither of these provisions to protect minors’ health reliably in all emergencies. 296 F.Supp.2d, at 65-66; 390 F.3d, at 61-62. And New Hampshire has conceded that, under our cases, it would be unconstitutional to apply the Act in a manner that subjects minors to significant health risks. See Reply Brief for Petitioner 2, 8, 11; Tr. of Oral Arg. 6, 14.

III

We turn to the question of remedy: When a statute restricting access to abortion may be applied in a manner that harms women’s health, what is the appropriate relief? Generally speaking, when confronting a constitutional flaw in a statute, we try to limit the solution to the problem. We prefer,*329 for example, to enjoin only the unconstitutional applications of a statute while leaving other applications in force, see United States v. Raines, 362 U.S. 17, 20-22, 80 S.Ct. 519, 4 L.Ed.2d 524 (1960), or to sever its problematic portions while leaving the remainder intact, United States v. Booker, 543 U.S. 220, 227-229, 125 S.Ct. 738, 160 L.Ed.2d 621 (2005).

Three interrelated principles inform our approach to remedies. First, we try not to nullify more of a legislature's work than is necessary, for we know that “[a] ruling of unconstitutionality frustrates the intent of the elected representatives of the people.” **968Regan v. Time, Inc., 468 U.S. 641, 652, 104 S.Ct. 3262, 82 L.Ed.2d 487 (1984) (plurality opinion). It is axiomatic that a “statute may be invalid as applied to one state of facts and yet valid as applied to another.” Dahmke-Walker Milling Co. v. Bondurant, 257 U.S. 282, 289, 42 S.Ct. 106, 66 L.Ed. 239 (1921). Accordingly, the “normal rule” is that “partial, rather than facial, invalidation is the required course,” such that a “statute may ... be declared invalid to the extent that it reaches too far, but otherwise left intact.” Brockett v. Spokane Arcades, Inc., 472 U.S. 491, 504, 105 S.Ct. 2794, 86 L.Ed.2d 394 (1985); see also Tennessee v. Garner, 471 U.S. 1, 105 S.Ct. 1694, 85 L.Ed.2d 1 (1985); United States v. Grace, 461 U.S. 171, 180-183, 103 S.Ct. 1702, 75 L.Ed.2d 736 (1983).

Second, mindful that our constitutional mandate and institutional competence are limited, we restrain ourselves from “rewrit[ing] state law to conform it to constitutional requirements” even as we strive to salvage it. Virginia v. American Booksellers Assn., Inc., 484 U.S. 383, 397, 108 S.Ct. 636, 98 L.Ed.2d 782 (1988). Our ability to devise a judicial remedy that does not entail quintessentially legislative work often depends on how clearly we have already articulated the background constitutional rules at issue and how easily we can articulate the remedy. In United States v. Grace, supra, at 180-183, 103 S.Ct. 1702, for example, we crafted a narrow remedy much like the one we contemplate today, striking down a statute banning expressive displays only as it applied to public sidewalks near the Supreme Court but not as it applied to the Supreme Court Building itself. We later explained that the remedy in Grace was a “relatively simple matter” because we had previously distinguished*330 between sidewalks and buildings in our First Amendment jurisprudence. United States v. Treasury Employees, 513 U.S. 454, 479, 115 S.Ct. 1003, 130 L.Ed.2d 964 (1995). But making distinctions in a murky constitutional context, or where line-drawing is inherently complex, may call for a “far more serious invasion of the legislative domain” than we ought to undertake. Ibid.

Third, the touchstone for any decision about remedy is legislative intent, for a court cannot “use its remedial powers to circumvent the intent of the legislature.” Califano v. Westcott, 443 U.S. 76, 94, 99 S.Ct. 2655, 61 L.Ed.2d 382 (1979) (Powell, J., concurring in part and dissenting in part); see also Dorcy v. Kansas, 264 U.S. 286, 289-290, 44 S.Ct. 323, 68 L.Ed. 686 (1924) (opinion for the Court by Brandeis, J.). After finding an application or portion of a statute unconstitutional, we must next ask: Would the legislature have preferred what is left of its statute to no statute at all? See generally Booker, supra, at 227, 125 S.Ct. 738; Minnesota v. Mille Lacs Band of Chippewa Indians, 552 U.S. 172, 191, 119 S.Ct. 1187, 143 L.Ed.2d 270 (1999); Alaska Airlines, Inc. v. Brock, 480 U.S. 678, 684, 107 S.Ct. 1476, 94 L.Ed.2d 661 (1987); Champlin Refining Co. v. Corporation Comm’n of Okla., 286 U.S. 210, 234, 52 S.Ct. 559, 76 L.Ed. 1062 (1932); The Employers'
In this case, the courts below chose the most blunt remedy—permanently enjoining the enforcement of New Hampshire's parental notification law and thereby invalidating it entirely. That is understandable, for we, too, have previously invalidated an abortion statute in its entirety because of the same constitutional flaw. In *Stenberg*, we addressed a Nebraska law banning so-called "partial birth abortion" unless the procedure was necessary to save the pregnant woman's life. We held Nebraska's law unconstitutional because it lacked a health exception. 530 U.S., at 930, 120 S.Ct. 2597 (lack of a health exception was an "independent reason" for finding the ban unconstitutional). But the parties in *Stenberg* did not ask for, and we did not contemplate, relief more finely drawn.

In the case that is before us, however, we agree with New Hampshire that the lower courts need not have invalidated the law wholesale. Respondents, too, recognize the possibility of a modest remedy: They pleaded for any relief "just and proper," App. 13 (Complaint), and conceded at oral argument that carefully crafted injunctive relief may resolve this case, Tr. of Oral Arg. 38, 40. Only a few applications of New Hampshire's parental notification statute would present a constitutional problem. So long as they are faithful to legislative intent, then, in this case the lower courts can issue a declaratory judgment and an injunction prohibiting the statute's unconstitutional application.

There is some dispute as to whether New Hampshire's legislature intended the statute to be susceptible to such a remedy. New Hampshire notes that the Act contains a severability clause providing that "[i]f any provision of this subdivision or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions or applications of this subdivision which can be given effect without the invalid provisions or applications." § 132:28. Respondents, on the other hand, contend that New Hampshire legislators preferred no statute at all to a statute enjoined in the way we have described. Because this is an open question, we remand for the lower courts to determine legislative intent in the first instance.

*332 IV*

Either an injunction prohibiting unconstitutional applications or a holding that consistency with legislative intent requires invalidating the statute *in toto* should obviate any concern about the Act's life exception. We therefore need not pass on the lower courts' alternative holding. Finally, if the Act does survive in part on remand, the Court of Appeals should address respondents' separate objection to the judicial bypass' confidentiality provision. The judgment of the Court of Appeals is vacated, and the case is remanded for further proceedings consistent with this opinion.

It is so ordered.

Ayotte v. Planned Parenthood of Northern New England

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Hospital brought action against city for cost of medical services rendered to person shot by police officer. Dismissal of the complaint by the Superior Court, Suffolk County, Massachusetts, was affirmed in part and reversed and remanded in part by the Supreme Judicial Court of Massachusetts, 385 Mass. 772, 434 N.E.2d 185. On grant of certiorari, the Supreme Court, Justice Blackmun, held that: (1) where there had been no formal adjudication of guilt against person shot by police officer, at the time that such person required medical care for which hospital sought recovery from city, Eighth Amendment had no application as basis for such recovery, and (2) city fulfilled its constitutional due process obligation by seeing that person injured by police was taken promptly to hospital providing treatment necessary for his injury, and as long as governmental entity ensures that medical care needed is in fact provided, Constitution does not dictate how cost of that care should be allocated as between the entity and provider of the care, but, rather, same is matter of state law.

Judgment of the Supreme Judicial Court reversed.

Justice Rehnquist, with whom Justice White joined, filed opinion concurring in part and concurring in the judgment.

Justice Stevens, filed opinion concurring in the judgment.

West Headnotes

170Bk502 Most Cited Cases
Where state court's decision was based on interpretation of federal law, United States Supreme Court had jurisdiction notwithstanding fact that same decision, had it rested on state law, would be unreviewable by the United States Supreme Court.

[2] Constitutional Law 42.1(1)
92k42.1(1) Most Cited Cases

Hospital which provided medical and hospital services to person shot by police officer had standing in Article III sense to bring action against city for redress of economic loss, on claim assertedly based on Eighth Amendment. U.S.C.A. Const. Art. 3, § 1 et seq.; Amend. 8.

170Bk504.1 Most Cited Cases
(Formerly 170Bk504)
Prudential reasons for refusing to permit a litigant to assert constitutional rights of a third party did not preclude consideration by Supreme Court of whether state court had properly required city, on Eighth Amendment grounds, to reimburse hospital for services provided to person shot by police officer, since consequence of holding that hospital could not assert the rights of the injured party would be to leave intact state court judgment in favor of the purportedly improper representative of the third party's constitutional right. U.S.C.A. Const.Amend. 8.

[4] Sentencing and Punishment 1433
350Hk1433 Most Cited Cases
(Formerly 110k1213.11, 110k1213)
Eighth Amendment's proscription of cruel and unusual punishments is violated by deliberate indifference to serious medical needs of prisoners, but Eighth Amendment scrutiny is appropriate only after the state has secured a formal adjudication of guilt. U.S.C.A. Const.Amend. 8.

92k299.3 Most Cited Cases
(Formerly 92k299(3))

[5] Sentencing and Punishment 1433
350Hk1433 Most Cited Cases
(Formerly 110k1213.11, 110k1213)
Where there had been no formal adjudication of guilt against person shot by police officer, at the time that such person required medical care for which hospital sought recovery from city, Eighth Amendment had no application as basis for such recovery; rather, the relevant constitutional provision was the due process clause of the Fourteenth Amendment. U.S.C.A. Const.Amends. 8, 14.

[6] Constitutional Law 262
92k262 Most Cited Cases
Due process clause requires responsible government or governmental agency to provide medical care to persons who have been injured while being apprehended by police, and such due process rights are at least as great as Eighth Amendment protections available to convicted prisoner. U.S.C.A. Const.Amends. 8, 14.

3. The relevant constitutional provision is not the Eighth Amendment but is, instead, the Due Process Clause of the Fourteenth Amendment. Although the Eighth Amendment's proscription of cruel and unusual punishments is violated by **2981 deliberate indifference to serious medical needs of prisoners, Eighth Amendment scrutiny is appropriate only after the State has secured a formal adjudication of guilt. Ingraham v. Wright, 430 U.S. 651, 97 S.Ct. 1401, 51 L.Ed.2d 711. Here, there had been no formal adjudication of guilt against the wounded person at the time he required medical care. P. 2983.

4. The Due Process Clause requires the responsible governmental entity to provide medical care to persons who have been injured while being apprehended by the police. However, as long as the governmental entity ensures that the medical care needed is in fact provided, the Constitution does not dictate how the cost of that care should be allocated as between the entity and the provider of the care, but, rather, same is matter of state law. U.S.C.A. Const.Amend. 14. **2980 Syllabus [FN*]

FN* The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See United States v. Detroit Lumber Co., 200 U.S. 321, 337, 26 S.Ct. 282, 287, 50 L.Ed. 499.

*239 A police officer of petitioner city wounded a suspect who was attempting to flee from the scene of a breaking and entering. The Massachusetts Supreme Judicial Court held that petitioner is liable for the medical services rendered by respondent hospital to the wounded person.

Held:

1. This Court does not lack jurisdiction to review the Massachusetts court's opinion on the asserted ground that the decision rested on an adequate and independent state ground. The Massachusetts court's opinion premised petitioner's liability squarely on the Eighth Amendment's prohibition of cruel and unusual punishments. Pp. 2981-2982.

2. Respondent has standing in the Art. III sense to raise its constitutional claim in this Court. Moreover, invoking prudential limitations on respondent's assertion of the rights of a third party (the wounded person) would serve no functional purpose. Cf. Craig v. Boren, 429 U.S. 190, 97 S.Ct. 451, 50 L.Ed.2d 397. Pp. 2982-2983.
the performance of their duties includes a corresponding duty to compensate the provider of that medical care.

I
On September 20, 1978, members of the police force of petitioner city of Revere, Mass., responded to a report of a breaking and entering in progress. At the scene they sought to detain a man named Patrick M. Kivlin, who attempted to flee. When repeated commands to stop and a warning shot failed to halt Kivlin's flight, an officer fired at Kivlin and wounded him. The officers summoned a private ambulance. It took Kivlin, accompanied by one officer, to the emergency room of respondent Massachusetts General Hospital (MGH) in Boston. [FN1] Kivlin was hospitalized at MGH from September 20 until September 29. Upon his release, Revere police served him with an arrest warrant that had been issued on September 26. Kivlin was arraigned and released on his own recognizance.

FN1. The city of Revere apparently has no municipal hospital or even a jail of its own. See App. 14.

On October 18, MGH sent the Chief of Police of Revere a bill for $7,948.50 for its services to Kivlin. The Chief responded immediately by a letter denying responsibility for the bill. On October 27, Kivlin returned to MGH for further treatment. He was released on November 10; the bill for services rendered during this second stay was $5,360.41. [FN2]

FN2. Nothing in the record indicates that MGH ever tried to obtain payment from Kivlin.

In January 1979, MGH sued Revere in state court to recover the full cost of its hospital services rendered to Kivlin. The Superior Court for the County of Suffolk dismissed the complaint. MGH appealed, and the Supreme Judicial Court of Massachusetts transferred the case to its own docket.

The Supreme Judicial Court reversed in part, holding "that the constitutional prohibition against cruel and unusual punishment, embodied in the Eighth Amendment to the United States Constitution [as applied to the States through the Fourteenth Amendment], requires that Revere be liable to the hospital for the medical services rendered to Kivlin during his first stay at the hospital." 385 Mass., 772, 774, 434 N.E.2d 185, 186 (1982). The court apparently believed that such a rule was needed to ensure that persons in police custody receive necessary medical attention. [FN3] In view of this rather novel Eighth Amendment approach and the importance of delineating governmental responsibility in a situation of this kind, we granted certiorari. 459 U.S. 820, 103 S.Ct. 48, 74 L.Ed.2d 55 (1982).

FN3. Because it ruled that Kivlin was no longer in custody when he returned to MGH on October 27, the court concluded that Revere was not liable to MGH for the services rendered during the second hospitalization. 385 Mass., at 779-780, 434 N.E.2d, at 189-190. That issue is not before us.

II
We first address two preliminary issues.

A
[1] MGH suggests that we lack jurisdiction to decide this case because the state court decision rests on an adequate and independent state ground. The Supreme Judicial Court's opinion, however, stated unequivocally that state contract law provided no basis for ordering Revere to pay MGH for the hospital services rendered to Kivlin, 385 Mass., at 774, 434 N.E.2d, at 186, and that MGH had not invoked the Commonwealth's Constitution in support of its claim, id., at 776, n. 6, 434 N.E.2d, at 188, n. 6. In a section of its opinion entitled "Eighth Amendment," the court premised Revere's liability squarely on the Federal Constitution. [FN4] Because the court's decision was based on an interpretation of federal law, we have jurisdiction notwithstanding the fact that the same decision, had it rested on state law, would be unreviewable here. See Oregon v. Hass, 420 U.S. 714, 719, and n. 4, 95 S.Ct. 1215, 1219, and n. 4, 43 L.Ed.2d 570 (1975).

FN4. The court stated: "The hospital argues that the prohibition against deliberate indifference to the medical needs of prisoners contained implicitly in the Eighth Amendment, Estelle v. Gamble, 429 U.S. 97, 97 S.Ct. 285, 50 L.Ed.2d 251 (1976), compels a government agency or division responsible for supplying those medical needs to pay for them. We agree." 385 Mass., at 776, 434 N.E.2d, at 187-188 (footnotes omitted).

Later, the court observed that inadequate funding, and the fact that payment would

violates state law, were irrelevant; the Eighth Amendment required such payment, and prevailed over contrary state law. *243 MGH, however, clearly has standing in the Article III sense: it performed services for which it has not been paid, and through this action it seeks to redress its economic loss directly.

Moreover, prudential reasons for refusing to permit a litigant to assert the constitutional rights of a third party are much weaker here than they were in *Craig v. Boren*. 429 U.S. 190, 193-194, 97 S.Ct. 451, 454-455, 50 L.Ed.2d 397 (1976), where the Court permitted a seller of beer to challenge a statute prohibiting the sale of beer to males, but not to females, between the ages of 18 and 21. In this case, as in Craig, the plaintiff's assertion of *jus tertii* was not contested in the lower court, see 385 Mass., at 776-777, n. 7, 434 N.E.2d, at 188, n. 7, and that court entertained the constitutional claim on its merits. Unlike Craig, this case arose in state court and the plaintiff, MGH, prevailed. The Supreme Judicial Court, of course, is not bound by the prudential limitations on *jus tertii* that apply to federal courts. The consequence of holding that MGH cannot assert the rights of a third party (Kivlin) in this Court, therefore, would be to dismiss the writ of certiorari, leaving intact the state court's judgment in favor of MGH, the purportedly improper representative of the third party's constitutional rights. See *Doremus v. Board of Education*. 342 U.S. 429, 434-435, 72 S.Ct. 394, 397-398, 96 L.Ed. 475 (1952). In these circumstances, invoking prudential limitations on MGH's assertion of *jus tertii* would "serve no *2983 functional purpose." *Craig v. Boren*. 429 U.S., at 194, 97 S.Ct., at 455. [FN5]

FN5 In addition, we could not resolve the question whether MGH has third-party standing without addressing the constitutional issue. To a significant degree, the case "is in the class of those where standing and the merits are inextricably intertwined." *Holzman v. Schlesinger*. 414 U.S. 1316, 1319, 94 S.Ct. 8, 10, 38 L.Ed.2d 28 (1973) (Douglas, J., in chambers). Both the standing question and the merits depend in part on whether injured suspects will be deprived of their constitutional right to necessary medical care unless the governmental entity is required to pay hospitals for their services.

**III**

**A**

[4][5] The Eighth Amendment's proscription of cruel and unusual punishments is violated by "deliberate indifference to serious "*244 medical needs of prisoners." *Estelle v. Gamble*, 429 U.S. 97, 104, 97 S.Ct. 285, 291, 50 L.Ed.2d 251 (1976). As MGH acknowledges, Brief for Respondent 3, on the facts of this case the relevant constitutional provision is not the Eighth Amendment but is, instead, the Due Process Clause of the Fourteenth Amendment. "Eighth Amendment scrutiny is appropriate only after the State has complied with the constitutional guarantees traditionally associated with criminal prosecutions.... [T]he State does not acquire the power to punish with which the Eighth Amendment is concerned until after it has secured a formal adjudication of guilt in accordance with due process of law." *Ingraham v. Wright*, 430 U.S. 651, 671-672, n. 40, 97 S.Ct. 1401, 1412-1413, n. 40, 51 L.Ed.2d 711 (1977); see *Bell v. Wolfish*, 441 U.S. 520, 535, n. 16, 99 S.Ct. 1861, 1872, n. 16, 60 L.Ed.2d 447 (1979). Because there had been no formal adjudication of guilt against Kivlin at the time he required medical care, the Eighth Amendment has no application.

**B**

[6][7] The Due Process Clause, however, does require the responsible government or governmental agency to provide medical care to persons, such as Kivlin, who have been injured while being apprehended by the police. In fact, the due process rights of a person in Kivlin's situation are at least as great as the Eighth Amendment protections available to a convicted prisoner. See *Bell v. Wolfish*, 441 U.S., at 535, n. 16, 545, 99 S.Ct., at 1872, n. 16, 1877. [FN6] We need not define, in this case, Revere's due process obligation to pretrial detainees or to other persons in its care who require medical attention. See *Youngberg v. Romeo*, 457 U.S. 307, 312, n. 11, 102 S.Ct. 2452, 2456, n. 11, 73 L.Ed.2d 28 (1982); *Norris v. Frame*, 585 F.2d 1183, 1187 (CA3 1978); *Loe v. Armistead*, 582 F.2d 1291 (CA4 1978), cert. denied, 446 U.S. 928, 100 S.Ct. 1865, 64 L.Ed.2d 281 (1980). Whatever the standard may be, Revere fulfilled its constitutional obligation by seeing that Kivlin was taken promptly to a hospital that provided the treatment necessary for his injury. And as long as the governmental entity ensures that the medical care needed is in fact
provided, the Constitution does not dictate how the cost of that care should be allocated as between the entity and the provider of the care. That is a matter of state law.

**FN6.** The due process issue, raised by respondent as an alternative ground in support of the judgment, has been fully briefed and is properly before us. See *Dandridge v. Williams*, 397 U.S. 471, 475-476, n. 6, 90 S.Ct. 1153, 1156-1157, n. 6, 25 L.Ed.2d 491 (1970). There is no reason to believe, moreover, that the Supreme Judicial Court's analysis of the rights of pretrial detainees would be any different under the Due Process Clause. No factual issues are in dispute, and there would be little point in remanding the case merely to allow the Supreme Judicial Court to reconsider its holding under the relevant constitutional provision.

If, of course, the governmental entity can obtain the medical care needed for a detainee only by paying for it, then it must pay. There are, however, other means by which the entity could meet its obligation. Many hospitals are subject to federal or state laws that require them to provide care to indigents. Hospitals receiving federal grant money under the Hill-Burton Act, for example, must supply a reasonable amount of free care to indigents. See 42 U.S.C. § 291c(e). In the Commonwealth of Massachusetts, any hospital with an emergency facility must provide emergency services regardless of the patient's ability to pay. *Mass.Gen.Laws Ann., ch. 111, § 70E(k)* (West), added by 1979 Mass.Acts, ch. 214, and amended by 1979 Mass.Acts, ch. 720. Refusal to provide treatment would subject the hospital to malpractice liability. § 70E. The governmental entity also may be able to satisfy its duty by operating its own hospital, or, possibly, by imposing on the willingness of hospitals and physicians to treat the sick regardless of the individual patient's ability to pay. [FN7]

**FN7.** Nothing we say here affects any right a hospital or governmental entity may have to recover from a detainee the cost of the medical services provided to him.

In short, the injured detainee's constitutional right is to receive the needed medical treatment; how the city of Revere obtains such treatment is not a federal constitutional question.**FN8** It is not even certain that mandating government reimbursement of hospitals that treat injured persons in police custody would have the effect of increasing the availability or quality of care. Although such a requirement would serve to eliminate any reluctance on the part of private hospitals to provide treatment, it also might encourage police to take injured detainees to public hospitals, rather than private ones, regardless of their relative distances or ability to furnish particular services.

**FN8.** We do not deal here, of course, with possible remedies for a pattern of constitutional violations.

IV

For these reasons, the judgment of the Supreme Judicial Court is reversed.

*It is so ordered.*

Justice REHNQUIST, with whom Justice WHITE joins, concurring in part and concurring in the judgment.

I see no reason to decide in this case what requirements the Due Process Clause may impose upon a governmental agency by way of providing medical care to persons who have been injured while being apprehended by the police. As the Court points out, "[w]hatever the standard may be, Revere fulfilled its constitutional obligation by seeing that Kivlin was taken promptly to a hospital that provided the treatment necessary for the injury." *Ante,* at 2983. The Court's other statements regarding the application of the Due Process Clause in this situation, *ante,* at 2983, are therefore unnecessary as well as largely unsupported.

I concur in parts I, II, IIIA, and IV of the Court's opinion.

Justice STEVENS, concurring in the judgment.

This case raises a question of state fiscal policy. If the Mayor of the City of Revere had paid this bill because he had been advised by his attorney, or by the Attorney General of the State, that it was an obligation of the municipality, we would have had no interest in the matter, even if the legal advice had misinterpreted federal law. If the Massachusetts Legislature had passed a statute requiring bills of this character to be paid by the city, the performance of a city's state statutory obligation would give rise to no federal question. That would be true even if the legislative history of the statute made it perfectly

clear that every lawmaker who voted for the bill did so because he believed that the Federal Constitution required the State to allocate the cost in this manner.

Because the Supreme Judicial Court of Massachusetts--rather than another branch of state government--invoked the Federal Constitution in imposing an expense on the City of Revere, this Court has the authority to review the decision. But is it a sensible exercise of discretion to wield that authority? I think not. There is "nothing in the Federal Constitution that prohibits a State from giving lawmaking power to its courts." *Minnesota v. Clover Leaf Creamery Co.*, 449 U.S. 456, 479, 101 S.Ct. 715, 731, 66 L.Ed.2d 659 (STEVENS, J., dissenting) (1981). No individual right was violated in this case. The underlying issue of federal law has never before been deemed an issue of national significance. Since, however, the Court did (unwisely in my opinion) grant certiorari, I join its judgment. [FN*]

FN* I agree with the Court's substantive analysis of this case, except for its assertion that the Eighth Amendment's prohibition against cruel and unusual punishment would not be violated by the State's imposition of cruel and unusual punishment on a prisoner before he has been convicted of a crime. I adhere to my views that the statements in support of that assertion in *Ingraham v. Wright*, 430 U.S. 651, 97 S.Ct. 1401, 51 L.Ed.2d 711 (1977), and *Bell v. Wolfish*, 441 U.S. 520, 99 S.Ct. 1861, 60 L.Ed.2d 447 (1979), simply cannot be squared with the text or the purpose of the Eighth Amendment. See *Ingraham, supra*, 430 U.S., at 684-692, 97 S.Ct., at 1419-1423 (WHITE, J., dissenting).

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Holdings: The Court of Appeals, Torruella, Circuit Judge, held that:
(1) Act lacked necessary exception for preservation of pregnant woman's health, and
(2) death exception to permit abortion when necessary to save life of pregnant woman was too narrow.
Affirmed.

West Headnotes

[1] Constitutional Law 42.1(1) 92k42.1(1) Most Cited Cases


Court of Appeals reviews district court's decision regarding constitutionality of statute de novo.

[3] Abortion and Birth Control 1.30 4k1.30 Most Cited Cases
Abortion statute which imposes undue burden on woman's decision before fetal viability is unconstitutional.

[4] Abortion and Birth Control 0.5 4k0.5 Most Cited Cases
Abortion regulation must contain exception for preservation of pregnant woman's health.

[5] Abortion and Birth Control 0.5 4k0.5 Most Cited Cases
Abortion regulation must contain adequate death exception to permit abortion when it is necessary to save life of pregnant woman.

[6] Abortion and Birth Control 1.30 4k1.30 Most Cited Cases
State's decision to require parental notification for minors seeking abortion is not constitutionally infirm per se.

[7] Abortion and Birth Control 1.30 4k1.30 Most Cited Cases
New Hampshire's Parental Notification Prior to Abortion Act was unconstitutional due to its lack of exception for preservation of pregnant woman's health; other provisions of New Hampshire law insulating medical personnel from civil liability or assault charges arising from giving treatment without consent did not provide functional equivalent to health exception, and conflicted with Act's provision of only three explicit exceptions to general prohibition. N.H.RSA 132:24 to 132:28.

[8] Statutes 188 361k188 Most Cited Cases

[8] Statutes 190 361k190 Most Cited Cases
Under New Hampshire law, court looks first to statute's plain meaning, and when it is clear and unambiguous, court applies statute as written.

[9] Abortion and Birth Control 1.30 4k1.30 Most Cited Cases
Judicial bypass provision of New Hampshire's Parental Notification Prior to Abortion Act did not satisfy constitutional requirement of exception for preservation of pregnant woman's health; delays of

1. Background

In June 2003, the New Hampshire legislature passed "AN ACT requiring parental notification before abortions may be performed on unemancipated minors," which states that:

No abortion shall be performed upon an unemancipated minor or upon a female for whom a guardian or conservator has been appointed pursuant to RSA 464-A because of a finding of incompetency, until at least 48 hours after written notice of the pending abortion has been delivered in the manner specified in paragraphs II and III.

Paragraph II specifies that "written notice shall be addressed to the parent at the usual place of abode of the parent and delivered personally to the parent by the physician or an agent." Paragraph III allows for notification by certified mail with return receipt requested and with restricted delivery to the addressee.

If a minor does not want her parent or guardian notified, she may request a state judge, after a hearing, to "authorize an abortion provider to perform the abortion if said judge determines that the

FN1. The Act defines an abortion as:

(1) The use or prescription of any instrument, medicine, drug, or any other substance or device intentionally to terminate the pregnancy of a female known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove an ectopic pregnancy or the products from a spontaneous miscarriage.

The notice requirement is waived if

(a) The attending abortion provider certifies in the pregnant minor's medical record that the abortion is necessary to prevent the minor's death and there is insufficient time to provide required notice; or

(b) The person or persons who are entitled to notice certify in writing that they have been notified.

If a minor does not want her parent or guardian notified, she may request a state judge, after a hearing, to "authorize an abortion provider to perform the abortion if said judge determines that the

pregnant minor is mature and capable of giving informed consent to the proposed abortion," or if the judge determines that "the performance of an abortion upon her without notification of her parent, guardian, or conservator would be in her best interests." RSA 132:26, II. In these proceedings, the pregnant minor may act on her own behalf or be appointed a guardian ad litem, and she must also be advised that she has a right to request court-appointed counsel. RSA 132:26, II(a). The court proceedings "shall be confidential and shall be given such precedence over other pending matters so that the court may reach a decision promptly and without delay so as to serve the best interest of the pregnant minor." RSA 132:26, II(b). Specifically, "[i]n no case shall the court fail to rule within 7 calendar days from the time the petition is filed." RSA 132:26, II(b). The judge must also "make in writing specific factual findings and legal conclusions," and order a record of the evidence to be maintained. RSA 132:26, II(b).

If the minor's petition is denied, an "expedited confidential appeal shall be available," *56 and the appellate court must rule within seven calendar days of the docketing of the appeal. Access to the trial and appellate courts for the purposes of these petitions "shall be afforded such a pregnant minor 24 hours a day, 7 days a week." RSA 132:26, II(c).

Violation of the Act can result in criminal penalties and civil liability:

Performance of an abortion in violation of this subdivision shall be a misdemeanor and shall be grounds for a civil action by a person wrongfully denied notification. A person shall not be held liable under this section if the person establishes by written evidence that the person relied upon evidence sufficient to convince a careful and prudent person that the representations of the pregnant minor regarding information necessary to comply with this section are bona fide and true, or if the person has attempted by reasonable diligence to deliver notice, but has been unable to do so. RSA 132:27. The Act was to take effect on December 31, 2003. 2003 N.H. Laws 173.


FN2. Citing Lujan v. Defenders of Wildlife, 504 U.S. 555, 112 S.Ct. 2130, 119 L.Ed.2d 351 (1992), amici New Hampshire Legislators argue that appellee abortion providers lack standing to challenge the Act because the injury giving rise to standing is speculative. The injury in question, according to amici, is the one suffered by pregnant minors who require an abortion for health reasons. Amici argue that it is "not sufficient to merely show that some unknown medical conditions exist that may at some unknown future date be suffered by some unknown minors." Brief of Amici New Hampshire Legislators at 8. In fact, Dr. Wayne Goldner listed in his unopposed declaration five specific conditions that could require abortion to protect a minor's health: preeclampsia, eclampsia, premature rupture of the membranes surrounding the fetus, spontaneous chorioamnionitis, and heavy bleeding during pregnancy. Declaration of Wayne Goldner, M.D., ¶¶ 8-15. Moreover, appellee abortion providers themselves face an imminent injury--civil or criminal prosecution for performing an abortion in violation of the Act--sufficient to confer on them Article III standing. See Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 62, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976) (holding that physician abortion providers asserting their own rights and those of their patients had standing to challenge abortion regulation and "should not be required to await and undergo a criminal prosecution as the sole means of seeking relief"). Because of their close relationship to the abortion decision, and the rights involved, providers routinely have *jus tertii* standing to assert the rights of women whose access to abortion is restricted. See Singleton v. Wulff, 428 U.S. 106, 117, 96 S.Ct. 2868, 49 L.Ed.2d 826 (1976) ("[I]t generally is appropriate to allow a physician to assert the rights of women patients as against governmental interference with the abortion decisions... "). Indeed, as the Ninth Circuit has noted, "physicians and clinics performing abortions are routinely

recognized as having standing to bring broad facial challenges to abortion statutes." Planned Parenthood of Idaho, Inc. v. Wasden, 376 F.3d 908, 916-18 (9th Cir.2004) (discussing abortion providers' third-party standing and citing cases).

The district court found unconstitutional both (1) the lack of an explicit exception to protect the health of the pregnant minor, and (2) the narrowness of the Act's exception *57 for abortions necessary to prevent the minor's death. Having found the Act fatally flawed in these respects, the district court declined to rule on the constitutionality of the Act's failure to provide specific protections for the confidentiality of a minor seeking a judicial waiver.

The Attorney General, acting in his official capacity, appeals.

II. Analysis

[2] We review the district court's decision regarding the constitutionality of a statute de novo. United States v. Lewko, 269 F.3d 64, 67 (1st Cir.2001).

The Attorney General argues that in deciding whether the Act is facially invalid we should apply the "no set of circumstances" standard set forth in United States v. Salerno, 481 U.S. 739, 107 S.Ct. 2095, 95 L.Ed.2d 697 (1987). [FN3] This standard requires plaintiffs' challenging a state law as facially invalid to show that "no set of circumstances exists under which the Act would be valid." Id. at 745, 107 S.Ct. 2095. The Attorney General's argument rests on the premise that the Salerno standard is applicable to the Act despite the agreement of a plurality of Justices in Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 876-77, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992), that a law which "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus" places an unconstitutional "undue burden" on the exercise of her right to choose abortion. A majority of the Casey Court applied that standard to determine that an abortion regulation is facially invalid if "in a large fraction of cases in which [the regulation] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion," thus imposing an "undue burden." Id. at 895, 112 S.Ct. 2791 (per Justices O'Connor, Kennedy, and Souter, joined by Justices Stevens and Blackmun). The Court has since confirmed that "a law designed to further the State's interest in fetal life which imposes an undue burden on the woman's decision before fetal viability' is unconstitutional."

FN3. In Salerno, the Court considered a facial challenge to the Bail Reform Act, 18 U.S.C. § 3142(e), which permits pretrial detention on the ground of dangerousness. The Court held that the provision in question, which was accompanied by strict procedural safeguards, did not constitute a facial violation of the Due Process or Excessive Bail clauses of the Constitution. Salerno, 481 U.S. at 755, 107 S.Ct. 2095.

[3] Despite the Supreme Court's clear application of the undue burden standard in Casey and Stenberg, it has never explicitly addressed the standard's tension with Salerno. In the instant case, while recognizing that this court has yet to address the issue, the district court followed the majority of circuits that apply the Casey and Stenberg standard to legislation regulating abortion. The Attorney General notes that the Supreme Court applied the Salerno standard in the abortion context prior to Casey, see, e.g., Ohio v. Akron Ctr. for Reprod. Health, 497 U.S. 502, 110 S.Ct. 2972, 111 L.Ed.2d 405 (1990), and urges us to follow the Fifth Circuit's decision in Barnes v. Moore, 970 F.2d 12, 14 n. 2 (5th Cir.1992), that Casey does not displace Salerno's "no set of circumstances" test for facial challenges to abortion regulation. See also Causeway Med. Suite v. Ieyoub, 109 F.3d 1096, 1102-03 (5th Cir.1997) (declining to reverse Barnes). The *58 overwhelming majority of circuits to address this issue, however, have disagreed with the Fifth Circuit. [FN4] See, e.g., Planned Parenthood of Cent. N.J. v. Farmer, 220 F.3d 127, 142-43 (3d Cir.2000) (holding undue burden standard, instead of Salerno standard, applies in abortion context after Casey); Planned Parenthood of S. Ariz. v. Lawall, 180 F.3d 1022, 1025-26 (9th Cir.1999) (noting inconsistency between Casey and Salerno, and following "great weight of circuit authority holding that Casey has overruled Salerno in the context of facial challenges to abortion statutes"), amended on denial of reh'g, 193 F.3d 1042 (9th Cir.1999); Women's Med. Prof. Corp. v. Voinovich, 130 F.3d 187, 193-96 (6th Cir.1997) (holding that Casey effectively overruled Salerno, cert. denied, 523 U.S. 1036, 118 S.Ct. 1347, 140 L.Ed.2d 496 (1998); Jane L. v. Bangert, 102 F.3d 1112, 1116 (10th Cir.1996) (observing that Supreme Court

applied undue burden test instead of Salerno test in Case v. Planned Parenthood, Sioux Falls Clinic v. Miller, 63 F.3d 1452, 1456-58 (8th Cir.1995) (opting to "follow what the Supreme Court actually did--rather than what it failed to say--and apply the undue-burden test."), cert. denied sub nom., Janklow v. Planned Parenthood, 517 U.S. 1174, 116 S.Ct. 1582, 134 L.Ed.2d 679 (1996); cf. A Woman's Choice-E. Side Women's Clinic v. Newman, 305 F.3d 684, 687 (7th Cir.2002) (reconciling conflict between Salerno, and Stenberg/Casey, by construing "no set of circumstances" language as a "suggestion" that gives way to Stenberg's holding that undue burden test applies), cert. denied, 537 U.S. 1192, 123 S.Ct. 1273, 154 L.Ed.2d 1026 (2003). We agree with these six circuit courts that the undue burden standard--proposed as a standard "of general application" by the Casey plurality, Casey, 505 U.S. at 876, 112 S.Ct. 2791, and twice applied to abortion regulations by a majority of the Court, id. at 895, 112 S.Ct. 2791; Stenberg, 530 U.S. at 920, 120 S.Ct. 2597--supersedes Salerno in the context of abortion regulation.

FN4. Only the Fourth Circuit has been sympathetic to the Barnes approach, indicating that it might continue to apply Salerno. See Manning v. Hunt, 119 F.3d 254, 268 n. 4 (4th Cir.1997) ("not[ing] in passing" that a court is bound to apply Salerno in abortion context unless the Supreme Court explicitly overrules it); Greenville Women's Clinic v. Bryant, 222 F.3d 157, 164-65 (4th Cir.2000) (noting that observation in Manning was not dicta and that Salerno must be applied to show deference to legislatures). But see, Greenville Women's Clinic v. Comm'r, S.C. Dept. of Health, 317 F.3d 357, 359 (4th Cir.2002) (on subsequent appeal, characterizing Bryant as holding, in part, that regulation in question "did not place an undue burden on a woman's decision whether to seek an abortion") (emphasis added).

[4][5] Complementing the general undue burden standard, the Supreme Court has also identified a specific and independent constitutional requirement that an abortion regulation must contain an exception for the preservation of a pregnant woman's health. See Stenberg, 530 U.S. at 929- 30, 120 S.Ct. 2597 (identifying "two independent reasons" for striking down a Nebraska regulation: first, that it lacks a health exception, and second, that it imposes an undue burden on a woman's ability to choose abortion). The origin of the health requirement can be traced to Roe, which held that "the State, in promoting its interest in the potentiality of human life, may ... regulate ... abortion [after fetal viability] except where necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *59Roe v. Wade, 410 U.S. 113, 164- 65, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973)(emphasis added), reaff'd Casey, 505 U.S. at 879, 112 S.Ct. 2791 (plurality opinion). The majority in Casey observed that, had the medical emergency exception to Pennsylvania's abortion restrictions--among them a parental consent requirement--precluded "immediate abortion despite some significant health risks," it would have been unconstitutional since "the essential holding of Roe forbids a State to interfere with a woman's choice to undergo an abortion ... if continuing her pregnancy would constitute a threat to her health." Casey, 505 U.S. at 880, 112 S.Ct. 2791. Finally, in Stenberg, 530 U.S. at 930, 120 S.Ct. 2597, the Supreme Court clarified that "the law requires a health exception in order to validate even a postviability abortion regulation, [and] it at a minimum requires the same in respect to previability regulations," 530 U.S. at 930, 120 S.Ct. 2597. Thus, a statute regulating abortion must contain a health exception in order to survive constitutional challenge. Similarly, Roe requires that abortion regulations contain an adequate death exception to permit abortion when it is necessary to save the life of a pregnant woman. Roe, 410 U.S. at 164-65, 93 S.Ct. 705.

[6] The instant case thus presents three questions: whether New Hampshire's Act contains an adequate health exception, whether it contains an adequate death exception, and whether it places an undue burden on unemancipated minors who wish to obtain an abortion. A state's decision to require parental notification for minors seeking an abortion is not constitutionally infirm per se. See Lambert v. Wicklund, 520 U.S. 292, 117 S.Ct. 1169, 137 L.Ed.2d 464 (1997) (upholding parental notification statute against constitutional challenge to judicial bypass procedure). The district court determined, however, that the New Hampshire Act's lack of a health exception and overly narrow death exception render it unconstitutional. Appellees argue that the Act also creates an undue burden by failing to adequately ensure the confidentiality of judicial bypass procedures.
A. Health exception

[7] The Attorney General and amici suggest that parental notification laws are shielded from the health exception requirement reiterated in Stenberg on account of the interests they aim to protect. [FN5] Parental notification laws are enacted not only in furtherance of the state's "interest in the potentiality of human life," Roe, 410 U.S. at 164, 93 S.Ct. 705, but also in the interest of protecting minors from undertaking the risks of abortion without the advice and support of a parent. In considering an abortion regulation based on interests other than the one identified in Roe, however, the Supreme Court has determined that it "cannot see how the interest-related differences could make any difference to the ... application of the 'health' requirement." *60 Stenberg, 530 U.S. at 931, 120 S.Ct. 2597; see also Casey, 505 U.S. at 877, 112 S.Ct. 2791 ("[A] statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." (emphasis added)) (plurality opinion). The Constitution requires a health exception even when the State's interest in regulation is "compelling." See Roe, 410 U.S. at 163, 93 S.Ct. 705; see also Stenberg, 530 U.S. at 931, 120 S.Ct. 2597 ("[A] State may promote but not endanger a woman's health when it regulates the methods of abortion."). Thus, regardless of the interests served by New Hampshire's parental notice statute, it does not escape the Constitution's requirement of a health exception.

FN5. Amicus Bishop of Manchester argues that Stenberg should be limited to cases in which a particular method of abortion is banned outright. This argument misreads the Court's discussion of the regulation at issue in that case. The majority did emphasize its prior caselaw "invalidat[ing] statutes that in the process of regulating the methods of abortion, impose[ ] significant health risks," 530 U.S. at 931, 120 S.Ct. 2597 (emphasis in original), but this language was meant to rebut Justice Thomas's dissent that a health exception was only applicable "where the pregnancy itself creates a threat to health." Id. (emphasis in original). To the contrary, the Court held, "a risk to a woman's health is the same whether it happens to arise from regulating a particular method of abortion, or from barring abortion entirely." Id. The risk is also the same when it arises from a minor's inability or unwillingness to notify her parents. The need for a health exception arises from the potential for risk to a woman's health, not from the source of that risk.

The Attorney General and amici also argue that our decision should be controlled by Hodgson v. Minnesota, 497 U.S. 417, 110 S.Ct. 2926, 111 L.Ed.2d 344 (1990), in which the Supreme Court upheld a parental notification statute that contained no health exception. However, as noted by the district court, the Hodgson Court did not consider a challenge to that statute's lack of a health exception, [FN6] and even if it had, the subsequent decisions in Casey and Stenberg would nevertheless require a health exception in the instant case. The additional cases cited by the Attorney General and amici as examples of parental notification or consent statutes upheld without a health exception are all similarly distinguishable. Only three times since Roe has the Supreme Court addressed a clear challenge to an abortion regulation's lack of a health exception. In all three, the Court has indicated that an exception must be provided when the restriction would place a woman's health at risk. See Stenberg, 530 U.S. at 930-38, 120 S.Ct. 2597 (requiring health exception for "partial-birth abortion" ban); Casey, 505 U.S. at 879-80, 112 S.Ct. 2791 (reading medical emergency exception to include threat to health); Thornburgh v. Am. Coll. of Obstetricians and Gynecologists, 476 U.S. 747, 768-71, 106 S.Ct. 2169, 90 L.Ed.2d 779 (1986) (finding statute requiring presence of second physician for post-viability abortion facially invalid for lack of medical emergency exception), overruled on other grounds, Casey, 505 U.S. at 882, 112 S.Ct. 2791.

FN6. A review of the Hodgson briefs indicates only one instance in which the impact of the parental notification statute on minors in need of an abortion for health reasons is discussed. In response to Minnesota's cross-petition to appeal the Eighth Circuit's determination that a two-parent notice requirement was unconstitutional in the absence of a judicial bypass, Cross-Respondents discussed the length to which some minors would go to avoid having to notify a parent. This might include delaying or foregoing abortion even when "serious health problems ... necessitate an immediate abortion." Brief for Cross-
Respondents at 15, Minnesota v. Hodgson, 497 U.S. 417, 110 S.Ct. 2926, 111 L.Ed.2d 344 (No. 88-1309). Such health problems, Cross-Respondents explained, were not covered by the statute's death exception. Id. at 15 n. 29. There was no argument that the notice requirement was unconstitutional because it lacked a health exception for such circumstances; rather, Cross-Respondents argued that a judicial bypass provision was constitutionally required, in part so that a minor would not feel compelled to forego an abortion needed for health reasons in order to avoid notifying her parents. Cross-Petitioners responded that no evidence had been provided of circumstances in which health problems short of a threat to a minor's life would necessitate abortion. Reply Brief of Cross-Petitioners at 17-18, Minnesota v. Hodgson, 497 U.S. 417, 110 S.Ct. 2926, 111 L.Ed.2d 344 (No. 88-1309). The Supreme Court addressed neither argument, although a majority did find the two-parent notice requirement unconstitutional in the absence of judicial bypass. Hodgson, 497 U.S. at 455, 110 S.Ct. 2926.

*61 Since Stenberg, at least two circuit courts have applied the health exception requirement to parental notice or consent laws. In Planned Parenthood of the Rocky Mountains Services, Corp. v. Owens, 287 F.3d 910, 915-16 (10th Cir.2002), the Tenth Circuit held that, because circumstances existed in which a pregnancy complication could seriously threaten a pregnant minor's health, a Colorado parental notification law similar to the New Hampshire Act was facially invalid for lack of a health exception. Similarly, the Ninth Circuit recently struck down an Idaho parental consent statute, finding that "[a] health exception is as requisite in statutory or regulatory provisions affecting only minors' access to abortion as it is in regulations concerning adult women." Planned Parenthood of Idaho, Inc. v. Wasden, 376 F.3d 908, 922-24 (9th Cir.2004) (finding Idaho statute's health exception overly narrow). We agree, and therefore affirm the district court's holding that the New Hampshire Act is constitutionally invalid in the absence of a health exception.

Acknowledging that the Act contains no explicit health exception, the Attorney General argues that other provisions of New Hampshire law provide a functional equivalent. None of the proffered statutes, however, is adequate. RSA 153-A:18 precludes civil liability for health professionals who render emergency medical care without consent, but it does not preclude criminal liability. RSA 676:6, VII(b) permits physicians and their assistants to use force in providing emergency medical care when no one competent to consent to such care is available. While RSA 676:6, VII(b) may preclude criminal liability for assault, it would not insulate a physician from criminal liability for violating the Act's notification provisions. See RSA 132:27 (providing that violation of the Act's notice requirement is a misdemeanor). Moreover, the proffered statutes insulate medical personnel from civil liability or assault charges that arise from giving treatment without consent; they do not provide such protection when the legal action arises from giving treatment to a consenting minor without first providing forty-eight hours' notice to her parent.

For the first time, in this appeal, the Attorney General also cites RSA 627:3, I, which codifies the "competing harms" defense to criminal liability for those who violate the law in order to avoid harm that "outweigh [s], according to ordinary standards of reasonableness, the harm sought to be prevented" by the criminal provision. Although this provision has the potential to protect against criminal liability under the Act, it cannot preclude civil liability. Moreover, the provision would leave providers uncertain whether, in any given circumstance, providing an abortion in violation of the Act would meet the "ordinary standards of reasonableness."

[8] Even if these statutes could be cobbled together to preclude all civil and criminal liability for medical personnel who violate the Act's notice requirements in order to preserve a minor's health, we would not view them as equivalent to the constitutionally required health exception. The basic canons of statutory construction in New Hampshire require us to look first to a statute's plain meaning, and when it is clear and unambiguous, to apply the statute as written. See, e.g., Appeal of Astro Spectacular, Inc., 138 N.H. 298, 639 A.2d 249, 250 (N.H.1996). The Act clearly states that "[n]o abortion shall be performed upon an unemancipated minor ... until at least 48 hours after written notice" to a parent. RSA 132:25. Three explicit exceptions to this rule are provided: (1) when abortion is necessary to prevent the minor's death; (2) when a parent certifies in writing that he or she has been notified; *62 and (3) when a court grants a judicial bypass. RSA 132:26, I, II. The New Hampshire legislature's intent that abortions not in compliance with the Act's notification provisions be prohibited in all but these three circumstances is clear. See St. Joseph Hosp. of
The New Hampshire Act contains no explicit health exception, and no health exception is implied by other provisions of New Hampshire law or by the Act's judicial bypass procedure. Thus, the Act is facially unconstitutional.

**B. Death exception**

Just as it requires a health exception, the Constitution also requires an exception to abortion restrictions when the life of a pregnant woman is in danger. *Stenberg*, 530 U.S. at 931, 120 S.Ct. 2597 ("[T]he governing standard requires an exception 'where it is necessary, in appropriate medical judgment for the preservation of the life or health of the mother.' ") (quoting *Casey*, 505 U.S. at 879, 112 S.Ct. 2791). Accordingly, the New Hampshire Act waives its parental notice requirement when a physician can certify that abortion is "necessary to prevent the minor's death and there is insufficient time to provide the required notice." *RSA 132:26, I(a).* Appellees argue that this death exception is unconstitutionally narrow because (1) it is not possible for a physician to determine with any certainty whether death will occur before the notice provisions could be complied with; (2) it does not allow for circumstances in which abortion is the best, but not the only, option for saving a minor's life; *FN7* and (3) it does not permit abortion providers to rely on their own good faith judgment about whether an abortion is necessary. The Attorney General does not refute these charges, but responds that the Act is sufficiently specific to give notice of prohibited conduct, and that a scienter requirement can be read into the Act from New Hampshire law.

The plaintiffs correctly identify that the Act, as currently formulated, would require a physician to use procedures that pose more risk to her patient's health in order to comply with the necessity provision of the death exception. *See Colautti v. Franklin*, 439 U.S. 379, 400, 99 S.Ct. 675, 58 L.Ed.2d 596 (1979) ("[T]he word 'necessary' suggests that a particular technique must be indispensable to the woman's life or health--not merely desirable--before it may be adopted."). Because we have already found unconstitutional the Act's failure to provide a health exception--which would remedy this problem by permitting abortion even in cases where a minor's death could be avoided by other, riskier means--we do not address this flaw as a separate ground for constitutional challenge.
choose between following the law and letting my patient's condition deteriorate, possibly past the point of being able to save her life at all, and alternatively providing appropriate medical care to my patient and risking criminal prosecution and being sued by her parents."). The threat of such sanctions will have a "profound chilling effect on the willingness of physicians to perform abortions" when a minor's life is at risk. Colautti, 439 U.S. at 396, 99 S.Ct. 675. Thus, the Act's death exception is drawn too narrowly to protect minors in need of a life-saving abortion.

The Attorney General apparently concedes that an abortion provider must be able to rely on his or her good faith medical judgment in determining whether her patient's life is in danger. See Colautti, 439 U.S. at 395, 99 S.Ct. 675 ("We need not now decide whether, under a properly drafted statute, a finding of bad faith or some other type of scienter would be required before a physician could be held criminally responsible for an erroneous determination of viability. We reaffirm, however, that the determination of whether a particular fetus is viable is, and must be, a matter for the judgment of the responsible attending physician."). The Attorney General argues that RSA 626:2, I, which states that 

"[a] person is guilty of a ... misdemeanor only if he acts purposely, knowingly, recklessly or negligently, as the law may require, with respect to each element of the offense," can be read together with the Act to provide the necessary scienter requirement. According to the Supreme Court of New Hampshire, "[w]here a specific mental state is not provided for the offense," RSA 626:2, I(a) requires "proof of a culpable mental state which is appropriate in light of the nature of the offense and the policy considerations for punishing the conduct in question." State v. Bergen, 141 N.H. 61, 677 A.2d 145, 146 (1996) (determining requisite mental state for indecent exposure). It is not clear, however, which of the four scienter requirements would be imposed in this circumstance. The definition of negligence imposes an objective reasonableness standard, see RSA 626:2. II(d), thus, a physician who acts on a good faith belief that abortion is necessary to save a patient's life could nonetheless face criminal or civil liability if a judge or jury later found that *64 the physician's assessment was unreasonable. See Voinovich, 130 F.3d at 205 ("In this area [of medical necessity] where there is such disagreement, it is unlikely that the prosecution could not find a physician willing to testify that the physician did not act reasonably.").

As the district court held, we cannot construe the Act to preclude liability for good faith judgments "unless such a construction is reasonable and readily apparent." Heed, 296 F.Supp.2d at 66-67 (quoting Stenberg, 530 U.S. at 944, 120 S.Ct. 2597). The Act gives no indication that the negligence standard set out in RSA 626:2, I should not be applied. Thus, a physician cannot know whether his or her determination that a minor's life is at risk will be judged according to a standard (e.g., knowingly) that respects her good-faith medical assessment, or by an objective standard (negligently) that would leave the physician's judgment open to post hoc second guessing. The resulting uncertainty would, again, impermissibly chill physicians' willingness and ability to provide lifesaving abortions. See Voinovich, 130 F.3d at 205 (finding medical emergency exception unconstitutionally vague "because physicians cannot know the standard under which their conduct will ultimately be judged"). As Dr. Goldner explained, "the Act forces doctors to think about criminal prosecution at a time when we need to be concentrating on doing what is best for our patients, thus creating unnecessary risk to patients' health and lives." Declaration of Wayne Goldner, M.D., at ¶ 19. That risk constitutes an undue burden for minors in need of life-saving abortions.

Because its time requirement is drawn too narrowly, and because it fails to safeguard a physician's good-faith medical judgment that a minor's life is at risk against criminal and civil liability, the Act's death exception is unconstitutional.

C. Confidentiality

The Act provides for judicial bypass of its notice provisions if, after a hearing, a judge "determines that the pregnant minor is mature and capable of giving informed consent to the proposed abortion," or, if she is not capable of giving informed consent, that "the performance of an abortion upon her without notification of her parent, guardian, or conservator would be in her best interests." RSA 132:26, II; cf. Bellotti v. Baird, 443 U.S. 622, 643-44, 99 S.Ct. 3035, 61 L.Ed.2d 797 (1979) (requiring parental consent laws to provide for judicial bypass on same grounds). Appellees argue that the Act does not adequately provide for the confidentiality of these judicial bypass procedures. The Act indicates that "[p]roceedings in the court ... shall be confidential," and "[a]n expedited confidential appeal shall be available." RSA 132:26, II(b)-(c).

Inadequate confidentiality provisions "raise the specter of public exposure and harassment of women.

who choose to exercise their personal, intensely private, right, with their physician, to end a pregnancy." Thornburgh, 476 U.S. at 767, 106 S.Ct. 2169; see also Bellotti v. Baird, 443 U.S. 622, 644, 99 S.Ct. 3035, 61 L.Ed.2d 797 (1979) (finding that judicial bypass proceeding "must assure that a resolution of the issue, and any appeals that follow, will be completed with anonymity"). In the instant case, a lack of confidentiality would also create a significant risk that a minor's parents could learn of her pregnancy and desire for an abortion, resulting in the very harms sought to be avoided by the bypass procedure. Alternatively, a minor might be compelled to delay or decline to seek an abortion out of fear that her parents would find out. Thus, for a large fraction of minors eligible for judicial bypass, inadequate confidentiality would impose an undue burden.

*65 [11] Confidentiality provisions must "take reasonable steps to prevent the public from learning of the minor's identity," but the Supreme Court has "refuse[d] to base a decision on the facial validity of a statute on the mere possibility of unauthorized, illegal disclosure by state employees." Akron Ctr., 497 U.S. at 513, 110 S.Ct. 2972. Considerable grey area is left between these two standards. Because we have already found the Act in its entirety unconstitutional on other grounds, however, we find it unnecessary to delve further into an evaluation of its confidentiality provisions.

III. Conclusion
For the reasons stated above, we affirm the district court's order declaring the Act unconstitutional and enjoining its enforcement.

Affirmed.

390 F.3d 53

Briefs and Other Related Documents (Back to top)


• 2004 WL 3421885 (Appellate Brief) Brief of Peter Heed, Attorney General of New Hampshire (Apr. 08, 2004)Original Image of this Document with Appendix (PDF)

• 04-1161 (Docket) (Jan. 30, 2004)

District Court of Appeal of Florida, Fourth District.

Harry K. SINGLETARY as Secretary of the Florida Department of Corrections, et al., Appellant, v.

Michael V. COSTELLO, Appellee. - 665 So.2d 1099, 21 Fla. L. Weekly D83

No. 95-0774.


Prison inmate who had gone on hunger strike to protest actions of Department of Corrections brought action for declaratory and injunctive relief seeking to enjoin state from providing nonconsensual medical care to inmate in event that intervention became necessary to preserve inmate's life. The Circuit Court, Martin County, Larry Schack, J., granted temporary injunction, and Department of Corrections appealed. The District Court of Appeal, Gunther, C.J., held that: (1) issue would be addressed even though inmate had ended hunger strike as issue was of great public importance and capable of repetition while evading effective review; (2) inmate had right under State Constitution to refuse medical care which was not vitiated by fact that he had been imprisoned; and (3) state did not have interest sufficient to override inmate's interest in refusing medical care.

Affirmed.

West Headnotes

[1] Appeal and Error 781(1)
30k781(1) Most Cited Cases

Appeal by Department of Corrections from order of trial court granting prison inmate's motion for temporary injunction which enjoined prison officials from taking actions to force-feed inmate who had gone on hunger strike to protest prison conditions was considered by Court of Appeals under its inherent jurisdiction, even though inmate had terminated his fast; issue of whether State could have taken steps which it had planned in event inmate's death became imminent was issue of great public importance capable of repetition while evading effective review.

[2] Injunction 132
212k132 Most Cited Cases

Temporary injunction is extraordinary remedy which should be granted sparingly and only after movant has alleged and proven facts which entitle movant to relief.

[3] Injunction 138.1
212k138.1 Most Cited Cases

In order for temporary injunction to be granted, plaintiff must prove that he will suffer irreparable harm unless status quo is maintained, that he has no adequate remedy at law, that he has clear legal right to relief requested, and that temporary injunction will serve public interest.

[4] Appeal and Error 920(3)
30k920(3) Most Cited Cases

[4] Appeal and Error 954(1)
30k954(1) Most Cited Cases

Trial court's ruling on injunction arrives at appellate court clothed in presumption of correctness, and will be reversed only upon showing of clear abuse of discretion.

92k18 Most Cited Cases

States may place more rigorous restraints on governmental intrusions than those imposed by Federal Constitution, and in any given state, Federal Constitution represents floor for basic freedoms, and State Constitution the ceiling.

92k82(7) Most Cited Cases


[7] Constitutional Law 82(13)
92k82(13) Most Cited Cases

[7] Health 914
198Hk914 Most Cited Cases

(Formerly 299k43.1 Physicians and Surgeons)

[7] Prisons 17(2)
310k17(2) Most Cited Cases

Prison inmate who was competent adult and who had
gone on hunger strike to protest actions of Department of Corrections had right under State Constitution to refuse life-saving medical procedures and to decide to forego any medical intervention should hunger strike reach point where intervention was necessary; inmate's constitutional right to refuse non-consensual medical treatment was not vitiated by fact that he was incarcerated.  


[8] Prisons 4(1)

310k4(1) Most Cited Cases

Lawful incarceration brings about necessary withdrawals or limitations of many privileges and rights; retraction is justified by considerations underlying penal system.

[9] Constitutional Law 82(13)

92k82(13) Most Cited Cases

[9] Convicts 1

98k1 Most Cited Cases

State has constitutional authority to deny basic civil rights, including right to vote and to serve on jury, to person convicted of felony; however, convicted prisoner does not forfeit all constitutional protections by reason of conviction and confinement.  West's F.S.A. § 944.292.

[10] Health 915

198hk915 Most Cited Cases

(Formerly 299k44 Physicians and Surgeons)

State's obligation to assure person's wishes regarding medical treatment must be respected, and can only be overcome if State has compelling state interest great enough to override constitutional right; additionally, means to carry out such compelling state interest must be narrowly tailored in least intrusive manner possible to safeguard rights of individual.  West's F.S.A. Const. Art. 1, § 23.

[12] Health 915

198hk915 Most Cited Cases

(Formerly 299k44 Physicians and Surgeons)

State interests which must be considered and balanced against individual's constitutional right to refuse medical treatment are preservation of life, protection of innocent third parties, prevention of suicide, and maintenance of ethical integrity of medical profession; generally, state interest in preservation of life is considered most significant, while maintenance of ethical integrity of medical profession is least significant.  West's F.S.A. Const. Art. 1, § 23.

[13] Health 915

198hk915 Most Cited Cases

(Formerly 299k44 Physicians and Surgeons)

Where individual is prison inmate, state interest in preservation of internal order and discipline, maintenance of institutional security, and rehabilitation of prisoners is implicated and must be considered in addition to factors of preservation of life, protection of innocent third parties, prevention of suicide, and maintenance of ethical integrity of medical profession in balancing state interests against individual's constitutional right to refuse medical treatment.  West's F.S.A. Const. Art. 1, § 23.

[13] Prisons 17(2)

310k17(2) Most Cited Cases

Interest of prison inmate who had gone on hunger strike to protest actions by Department of Corrections in refusing non-consensual medical treatment was not outweighed by interests of State, and State could not administer medical care against inmate's wishes if necessary to preserve inmate's life; interest in preservation of life by itself did not justify intervention, interest of preventing suicide was not implicated as inmate did not want to die but sought resolution of his complaints as desired end of hunger strike, and no showing was made that inmate's actions undermined security, safety, or welfare within prison.  West's F.S.A. Const. Art. 1, § 23.

[14] Health 903

198hk903 Most Cited Cases

(Formerly 299k42 Physicians and Surgeons)

State interest in protection of innocent third parties arises, and must be considered in balancing state's interests against individual's constitutional right to refuse medical treatment, when refusal of medical treatment endangers public health or implicates emotional or financial welfare of patient's minor child.  West's F.S.A. Const. Art. 1, § 23.
While state interest in preservation of life is powerful, it will not in and of itself foreclose competent person from declining life-saving medical treatment, as life state is trying to protect is life of same person who has competently decided to forego medical intervention. West's F.S.A. Const. Art. 1, § 23.

Injunction 138.60

Trial court did not abuse its discretion in enjoining prison officials from providing any medical assistance or treatment to inmate who had gone on hunger strike to protest actions of Department of Corrections and who had expressed desire that life-saving procedures not be undertaken should hunger strike reach point where intervention was necessary to save inmate's life; State's interests did not outweigh prisoner's fundamental interest in refusing medical treatment. West's F.S.A. Const. Art. 1, § 23.

Costello stated that he was maintaining a fast to protest the actions of the Department of Corrections (DOC). Apparently, Costello was fasting to protest his punitive transfer from Polk Correction Institution to Martin Correctional Institution as well as to protest an allegedly false disciplinary report filed against a Chaplain in the Polk Correctional Institution. Accordingly, Costello sought a declaratory judgment permitting him to “continue his fast devoid of non-consensual medical intervention.” Thus, Costello sought to enjoin and restrain Appellants from “imposing non-consensual medical intervention ... or hindering or interfering with [Costello’s] fast.”

A two-day evidentiary hearing was held wherein Costello proceeded pro-se. At the hearing, only Dr. Becker and Costello testified. Initially, Dr. Becker testified that Costello was in an infirmary lockdown cell due to his self-declared hunger strike. According to the doctor, not intervening in such a circumstance would result in suicide.

Appellants, Harry K. Singletary, as Secretary of the Florida Department of Corrections, Franklin H. Becker, Chester Lambdin and the Department of Corrections, defendants below (Appellants), appeal a temporary injunction enjoining them from providing any medical treatment, assistance, testing or procedure of any form or kind to or upon the appellee, Michael V. Costello (Costello). Because we determine Appellants failed to prove that compelling state interests outweighed Costello's privacy right, we affirm.

In 1969, Costello was sentenced to life imprisonment for first degree murder. On or about January 11, 1995, Costello filed a pro se complaint against Appellants for declaratory and injunctive relief. Costello alleged that he had been on a total fast since January 3, 1995 to object to and protest the actions of
wrongs committed by the DOC. Finally, Costello realized that if he continued his hunger strike without medical intervention from Appellants, death was imminent.

Eventually, the trial court entered an order granting Costello's motion for temporary injunction. The trial court determined that Costello had a constitutional and fundamental right to refuse medical treatment and that Appellants failed to establish a compelling state interest to override the same. Therefore, the trial court ordered the following:

... the Defendants Harry K. Singletary and the Florida Department of Corrections, and their officers, agents, servants, employees, attorneys, and all other persons in active concert or participation with any of them, are hereby enjoined from:

1) providing any medical treatment, assistance, testing or procedure, of any form or kind, to or upon the Plaintiff without the specific consent of the Plaintiff; ....

FN1. Although no actual case is in controversy, we hereby exercise our inherent jurisdiction to decide this issue of great public importance that is capable of repetition while evading effective review. Holly v. Auld, 450 So. 2d 217 (Fla. 1984); Fev v. Curtis, 624 So. 2d 770 (Fla. 4th DCA 1993).

[2][3][4] A temporary injunction is an extraordinary remedy which should be granted sparingly and only after the movant has alleged and proven facts entitling the movant to relief. Hiles v. Auto Bahn Fed’n, Inc., 498 So. 2d 997 (Fla. 4th DCA 1986). In order for a temporary injunction to be granted, a plaintiff must prove that:

1) he will suffer irreparable harm unless the status quo is maintained; (2) he has no adequate remedy at law; (3) he has a clear legal right to the relief requested; and (4) a temporary injunction will serve the public interest.

South Fla. Limousines, Inc. v. Broward County Aviation Dep’t, 512 So. 2d 1059, 1061 (Fla. 4th DCA 1987). A trial court's ruling on a motion for an injunction arrives at the appellate court clothed in a presumption of correctness and will be reversed only upon a showing of a clear abuse of discretion. Id. at 1062; M.G.K. Partners v. Cavallo, 515 So. 2d 368 (Fla. 4th DCA 1987).

Quite obviously, the instant case centers around whether Costello has the legal right to the injunctive relief requested. That is, whether Costello has the legal right, as a prisoner, to refuse medical treatment and intervention when the need for the treatment and intervention stems from a self-induced hunger strike. In order to resolve this issue, it is necessary to determine the breadth of an individual's right to refuse medical treatment.

Both the federal and Florida constitutions protect an individual's right to refuse medical care. In the seminal case of Cruzan v. Director, Missouri Department of Health, 497 U.S. 261, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990), the United States Supreme Court determined that Missouri's clear and convincing evidentiary standard, before the termination of a life support system, did not interfere with a competent person's right to refuse medical treatment. More importantly, the Supreme Court concluded, after a thorough review of informed consent cases, that a competent person has a liberty interest under *1103 the Due Process Clause in refusing unwarranted medical treatment. 497 U.S. at 277, 110 S.Ct. at 2851, 111 L.Ed.2d at 241. The high court reasoned that the logical corollary to the doctrine of informed consent is the conclusion that the patient generally possesses the right not to consent. 497 U.S. at 270, 110 S.Ct. at 2847, 111 L.Ed.2d at 236. Thus, for the purposes of that case, the Supreme Court assumed that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition. 497 U.S. at 279, 110 S.Ct. at 2852, 111 L.Ed.2d at 242.

[5][6] Nevertheless, under the federalist system of government, states may place more rigorous restraints on governmental intrusions than those imposed by the federal constitution. Travlor v. State, 596 So. 2d 957, 961 (Fla. 1992). As explained by the Florida Supreme Court, "in any given state, the federal Constitution thus represents the floor for basic freedoms; the state constitution, the ceiling." Id. at 962. Unlike the federal and most state constitutions,
Florida has a specific provision regarding an individual's right to privacy. Article I, Section 23 of the Florida Constitution provides:

Every natural person has the right to be let alone and free from governmental intrusion into his private life except as otherwise provided herein. This section shall not be construed to limit the public's right of access to public records and meetings as provided by law.

This explicit constitutional right embraces more privacy interests and extends more protection that the right to privacy provided under the Due Process Clause of the federal constitution. In re T.W., 551 So.2d 1186, 1192 (Fla.1989). As recognized by the supreme court,

[t]he citizens of Florida opted for more protection from governmental intrusion when they approved article I, section 23, of the Florida Constitution. This amendment is an independent, freestanding constitutional provision which declares the fundamental right to privacy. Article I, section 23, was intentionally phrased in strong terms. The drafters of the amendment rejected the use of the words "unreasonable" or "unwarranted" before the phrase "governmental intrusion" in order to make the privacy right as strong as possible. Since the people of this state exercised their prerogative and enacted an amendment to the Florida Constitution which expressly and succinctly provides for a strong right of privacy not found in the United States Constitution, it can only be concluded that the right is much broader in scope than that of the Federal Constitution.

Winfield v. Division of Pari-Mutuel Wagering, Dep't of Business Regulation, 477 So.2d 544, 548 (Fla.1985).

Not surprisingly, this broad, explicit privacy right has been applied in medical decision-making cases. See Rasmussen v. South Fla. Blood Serv., 500 So.2d 533 (Fla.1987) (society's interest in maintaining a strong volunteer blood donation system outweighed AIDS victim's right to subpoena names of blood donors); Public Health Trust of Dade County v. Wons, 541 So.2d 96 (Fla.1989) (Jehovah Witness has fundamental right to refuse blood transfusion without which she may die). The leading case in Florida defining the right to medical decision-making is In re Browning, 568 So.2d 4 (Fla.1990). Mrs. Browning was left in a vegetative state after suffering a stroke which destroyed the portion of her brain which controlled cognition. Browning, 568 So.2d at 8. The stroke left Browning in a noncommunicative state, existing only by virtue of fluid and nutrition supplied by a nasogastric tube. Id. at 9. Pursuant to a living will, Browning's guardian petitioned to terminate the nasogastric feeding. Id. at 8. The supreme court determined that the guardian could, without prior judicial approval, discontinue the nasogastric feeding in accordance with Browning's prior instructions. Id. at 17.

In discussing the right to privacy, the supreme court determined that article I, section 23 provided an explicit textual foundation for those privacy interests inherent in the concept of liberty. Id. at 10 (citing Rasmussen v. South Fla. Blood Serv., Inc., 500 So.2d 533, 536 (Fla.1987)). The Browning court then determined

*[1104] [w]e can conceive of few more personal or private decisions concerning one's body that one can make in the course of a lifetime ... [than] the decision of the terminally ill in their choice of whether to discontinue necessary medical treatment.

Id. (citing In re T.W., 551 So.2d 1186, 1192 (Fla.1989)). Thus, the supreme court concluded

... a competent person has the constitutional right to choose or refuse medical treatment and that right extends to all relevant decisions concerning one's health. Courts overwhelmingly have held that a person may refuse or remove artificial life-support, whether supplying oxygen by a mechanical respirator or supplying food and water through a feeding tube. We agree and find no significant legal distinction between these artificial means of life support.

Id. at 11-12. In a footnote, the supreme court reinforced the all encompassing nature of this right by stating ":[w]e see no reason to qualify that right on the basis of the denomination of a medical procedure as major or minor, ordinary or extraordinary, life-prolonging, life-maintaining, life-sustaining, or otherwise." Id. at 11, n. 6.

[7] Based upon the expansive interpretation given to article I, section 23, it becomes evident that Costello, as a competent adult, had the right to refuse life-saving medical procedures. Costello was a competent adult who made a voluntary, conscious choice concerning his medical options. Costello, as a lucid adult, decided to forego any medical intervention should his hunger strike reach a point when such intervention was necessary. Accordingly, we preliminarily hold that such a determination falls within the broad scope attributable to Florida's privacy right.

[8][9] Having concluded that Costello enjoys the right to make a conscious decision concerning his...
medical options, it is now necessary to determine whether his status as a prisoner vitiated this right. It is firmly established that lawful incarceration brings about the necessary withdrawals or limitations of many privileges and rights, a retraction justified by the considerations underlying the penal system. Price v. Johnston, 334 U.S. 266, 68 S.Ct. 1049, 92 L.Ed. 1356 (1948). Accordingly, the state of Florida has the constitutional authority to deny basic civil rights, including the right to vote and to serve on a jury, to a person convicted of a felony. Calhoux v. Department of Health and Rehab. Servs., 500 So.2d 674 (Fla. 3d DCA 1987); § 944.292, Fla.Stat. (1993). However, a convicted prisoner does not forfeit all constitutional protections by reason of the conviction and confinement. O'Lone v. Estate of Shabazz, 482 U.S. 342, 107 S.Ct. 2400, 96 L.Ed.2d 282 (1987).

Only one Florida case has alluded to a prisoner's right of privacy. In Metropolitan Dade County v. P.L. Dodge Foundations, Inc., 509 So.2d 1170 (Fla. 3d DCA 1987), the appellate court was confronted with a case involving a hospital's claim for payment for the treatment of a prison inmate. Apparently, a prisoner was transferred to Dodge Memorial Hospital for a psychiatric evaluation and treatment. Id. at 1171. Thereafter, the hospital sued and obtained a summary judgment against the county for the outstanding bill. Id. In reversing, the third district concluded that the prisoner remained liable unless it was first established that the prisoner-patient was indigent. Id. at 1175-76. Importantly, the third district preliminarily determined that "a prisoner, like any ordinary citizen, may not forcibly by given medical treatment without his express or implied consent." Id. at 1172.

In accord with the above opinion is a 1975 attorney general's opinion. In this opinion, the attorney general was faced with the following question:
May the Division of Corrections forcibly treat an inmate patient who has refused medical or surgical treatment deemed necessary to save the inmate's life?

Op.Att'y Gen.Fla. 75-28 (1975). The attorney general determined that although deprived of liberty, a prisoner retains all other rights of ordinary citizens except those expressly or by necessary implication taken away by law. Id. at 75-29. Thereafter, the opinion noted that an ordinary citizen may not be forcibly treated without his or her implied consent. Id. Thus, because there were no express authority to forcibly treat a prisoner, the attorney general concluded:

... it is my opinion that prisoners are governed by the same rule and may not be forcibly treated without consent, even though such treatment is necessary to save the prisoner's life.

Id.

Although section 944.35(1)(f)(2) allows the DOC to use force in administering medical treatment, we hold that a prisoner retains the fundamental right to privacy espoused by Article I, section 23 of the Florida Constitution. Accordingly, Costello possessed a fundamental right to refuse non-consensual medical treatment even though he was incarcerated.

[10][11] Having established that Costello, as a prison inmate, enjoys a constitutionally protected fundamental right to refuse non-consensual medical intervention, it is now necessary to delineate and balance the various state interests. The state's obligation to assure a person's wishes regarding medical treatment must be respected and can only be overcome if the state has a compelling state interest great enough to override this constitutional right. In re Browning, 568 So.2d 4, 13-14 (Fla.1990). Additionally, the means to carry out such a compelling state interest must be narrowly tailored in the least intrusive manner possible to safeguard the rights of the individual. Id at 14.

[12][13] The Florida Supreme Court has repeatedly identified four state interests which must be considered and balanced against an individual's right to refuse medical treatment:
1. the preservation of life;
2. the protection of innocent third parties;
3. the prevention of suicide; and
4. the maintenance of the ethical integrity of the medical profession.

In re Browning, 568 So.2d at 14. In addition, because Costello is a prison inmate, the state interest in the "preservation of internal order and discipline, the maintenance of institutional security, and the rehabilitation of prisoners" is implicated. Commissioner of Correction v. Myers, 379 Mass. 255, 399 N.E.2d 452, 457 (1979). As noted by the supreme court, these state interests

... are by no means a bright-line test, capable of resolving every dispute regarding the refusal of medical treatment. Rather, they are intended merely as factors to be considered while reaching the difficult decision of when a compelling state interest may override the basic constitutional right[s] of privacy....

Public Health Trust of Dade County v. Wons, 541
[14] Generally, the state interest in the preservation of life is considered the most significant. In re Browning, 568 So.2d 4, 14 (Fla.1990). In discussing this particular interest, the supreme court distinguished between curable and terminable afflictions.

The state's interest in the preservation of life generally is considered the most significant state interest. However, "there is a substantial distinction in the State's insistence that human life be saved where the affliction if curable, as opposed to the State interest where, as here, the issue is not whether, but when, for how long and at what cost to the individual [his] or her life may be briefly extended." [citations omitted].

Id. at 14. While the interests in the prevention of suicide and the maintenance of institutional security are self-explanatory, the interest in the protection of innocent third parties arises when the refusal of medical treatment endangers public health or implicates the emotional or financial welfare of the patient's minor child. Thor v. Superior Court, 5 Cal.4th 725, 21 Cal.Rptr.2d 357, 855 P.2d 375 (1993). The last and least significant of the aforementioned state interests is the maintenance of ethical integrity of the medical profession. In re Browning, 568 So.2d 4, 14 (Fla.1990). According to this court: [r]ecognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State's interest in protecting the same.


Although the Florida judiciary has not been faced with a case wherein it was necessary to balance the various state interests against a prisoner's right to engage in a hunger strike, several foreign jurisdictions have expressly and explicitly considered the issue. In In re Caulk, 125 N.H. 226, 480 A.2d 93 (1984), the supreme court of New Hampshire determined that a prison inmate had no constitutional right to starve himself to death even though the decision to do so was made knowingly and voluntarily. In Caulk, the inmate did not make any demands during his hunger strike, but rather his course of conduct was aimed at achieving one goal, death. Caulk, 480 A.2d at 95. After noting that the inmate enjoys a constitutional right to privacy, the New Hampshire court concluded that the state interest in the maintenance of institutional security was implicated:

Within the State prison, the State's interests, among others, involve the preservation of internal order and discipline and the maintenance of institutional security. [citations omitted]...

In addition to necessitating special treatment for himself, the defendant's actions have the potential of causing more widespread institutional problems. If the defendant is successful in evading the prison's control over his behavior, this may jeopardize prison discipline and tax prison resources. [citations omitted]. We agree with the State that prison officials will lose much of their ability to enforce institutional order if any inmate can shield himself from the administration's control and authority by announcing that he is on a starvation diet. Prisoners are not permitted to live in accordance with their own desires, nor may they be permitted to die on their own terms without adversely and impermissibly affecting the State's legitimate authority over inmates. [citations omitted].

Id. at 96. The New Hampshire high court also found the state interest in the prevention of suicide implicated.

Although the defendant contends that he is allowing himself to die, rather than committing suicide, it is important to note what this case does not involve. This is not a situation where an individual, facing death from a terminal illness, chooses to avoid extraordinary and heroic measures to prolong his life, albeit for a short duration. Rather, the defendant has set the death-producing agent in motion with the specific intent of causing his own death [citations omitted], and any comparison of the two situations is superficial. Id. at 97. Accordingly, the Caulk court concluded that the state's interests in preserving life, preventing suicide and maintaining an effective criminal justice system outweighed the prisoner's right to privacy. Id.; see also Von Holden v. Chapman, 87 A.D.2d 66, 450 N.Y.S.2d 623 (1982) (utilizing the preservation of life and prevention of suicide, coupled with evidence that hunger strike disrupted prison order, to determine prison inmate did not have right to starve himself to death).

Similarly, in Department of Public Welfare, Farview State Hospital v. Kallinger, 134 Pa.Cmwlth. 415, 580
In addition to the state interest in maintaining order within the prison system, the Pennsylvania court determined that the interests in the preservation of human life and the prevention of suicide were implicated. Id. at 891-92. Finally, the Kallinger court concluded that the integrity of the medical profession must be factored into the balancing equation. Id., 580 A.2d at 892. Thus, the Pennsylvania court concluded:

The Commonwealth of Pennsylvania has an overwhelming interest in the orderly administration of its prison system. The Commonwealth must maintain prison security, order and discipline. It must also fulfill its duty to provide proper medical care to the inmates, thus preserving life and preventing suicide. These vital interests, along with the need to preserve the integrity of the physicians and psychiatrists working within the penal system, clearly outweigh any diminished right to privacy held by Kallinger. Id. at 893.

Federal decisions seem to be in accord with the above cases. In In re Sanchez, 577 F.Supp. 7 (S.D.N.Y. 1983), the New York district court granted the state's application to force feed a contemnor on a hunger strike. Apparently, the contemnor began a hunger strike to demonstrate his sincerity of his position that his continued imprisonment would have no effect upon his unwillingness to testify. Id. at 8. Although the court noted that a prisoner on a hunger strike, weakened to the point of physical incapacity, did not present a threat to prison security, the court stressed the fact that federal regulations provided for forced medical treatment if it is determined that the inmate's life or permanent health would be threatened if treatment is not initiated immediately. Id.; see also 28 C.F.R. § 549.65(a) (1993). After outlining the contemnor's right to privacy, the district court concluded:

Under the special circumstances of this case, the Government's application must be granted. Mr. Sanchez is not on a hunger strike as a means of demonstrating on behalf of some political cause or religious belief ... Nor is his situation analogous to a patient refusing life prolonging treatment. Rather, Sanchez is, by his own admission, attempting to bring maximum pressure to bear upon the Judge who will ultimately rule upon his motion to vacate the contempt order. Moreover, the prolongation of this hunger strike will soon render Mr. Sanchez physically or mentally incapable of testifying before the grand jury, thereby rendering further coercive sanctions futile. In one sense, therefore, Mr. Sanchez is attempting to escape from prison and to frustrate the lawful authority of the courts. This is a purpose that we cannot condone. Id. at 9.

In contrast to the above cases is the Georgia case of Zant v. Prevatte, 248 Ga. 832, 286 S.E.2d 715 (1982). In Zant, the inmate, when sane and rational, decided to engage in a hunger strike to get the attention of the prison officials. Id., 286 S.E.2d at 716. The lower court in Zant determined that the state had no right to interfere with the inmate's hunger strike:

The State has no right to monitor this man's physical condition against his will; neither does it have the right to feed him to prevent his death from starvation if that is his wish ... The State can incarcerate one who has violated the law and, in certain circumstances, even take his life. But it has no right to destroy a person's will by frustrating his attempt to die if necessary to make a point. Id., 286 S.E.2d at 716-17. The Georgia supreme court affirmed the lower court's decision disallowing state interference stating:
Prevatte is not mentally incompetent, nor does he have dependents who rely on him for a means of livelihood. The issue of religious freedom is not present. Under this circumstances, we hold that Prevatte, by virtue of his right to privacy, can refuse to allow intrusions on his person, even though calculated to preserve his life. The State has not shown such a compelling state interest in preserving Prevatte's life, as would override his right to refuse medical treatment. Id. at 717.

Similar to Zant and more recent is the California case of Thor v. Superior Court, 5 Cal.4th 725, 21 Cal.Rptr.2d 357, 855 P.2d 375 (1993). In Thor, because a quadriplegic inmate intermittently refused to be fed, a prison doctor petitioned the trial court for an order allowing him to use a gastrojejunostomy or percutaneous gastrostomy tube to feed and medicate the inmate. Id., 21 Cal.Rptr.2d at 361, 855 P.2d at 369. After thoroughly discussing the right "to be left alone," the California Supreme Court concluded, as a general proposition that a physician has no duty to treat an individual who declines medical intervention after "reasonable disclosure of the available choices with respect to proposed therapy (including non-treatment) and of the dangers inherently and potentially involved in each." [citations omitted]. The competent adult patient's "informed refusal" supersedes and discharges the obligation to render further treatment. Id., 21 Cal.Rptr.2d at 365, 855 P.2d at 383.

Thereafter, the Thor court discussed, and ultimately subrogated the various state interests to the privacy right of the individual. With regard to the preservation of life, the high court quoted Justice Brennan from his dissenting opinion in Cruzan v. Director, Missouri Department of Health, 497 U.S. 261, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990):

Thus, "(w)hile both of the( ) state interests in life are certainly strong, in themselves they will usually not foreclose a competent person from declining life-sustaining medical treatment.... This is because the life that the state is seeking to protect in such a situation is the life of the same person who has competently decided to forego the medical intervention; it is not some other actual or potential life that cannot adequate protect itself." [citations omitted]. Id., 21 Cal.Rptr.2d at 366, 855 P.2d at 384.

Subsequently, the Thor court dismissed the state interest in the prevention of suicide because no state interest is compromised by allowing an individual to experience a dignified death rather than an excruciatingly painful life. Id., 21 Cal.Rptr.2d at 367, 855 P.2d at 385 (quoting Donaldson v. Lungren, 2 Cal.App.4th 1614, 4 Cal.Rptr.2d 59, 63 (1992)). Thereafter, the court found inapplicable the state interest in the protection of innocent third parties because the inmate was childless. Id., 21 Cal.Rptr.2d at 369, 855 P.2d at 387.

The Thor court then proceeded to discuss the privacy right in light of Andrews' status as a prisoner. After recognizing that incarceration necessarily limits an individual's freedom, the California high court focused on the specific facts adduced in the case. In refusing to consent to further treatment, Andrews is exercising his fundamental right of self-determination in medical decisions. Petitioner has offered no evidence that allowing him to do so undermines prison integrity or endangers the public. [footnote omitted]. Thus, considering the magnitude of the right at issue ... we hold that petitioner must accede to Andrews' decision and may not force him to accept unwanted treatment. [citations omitted].

We are not unmindful of the difficulties involved in maintaining an orderly and secure penal institution; and our holding does not imply any attenuation of the deference accorded the experience and expertise of administrative officials in such matters. [citations omitted]. In another case, or in this case if a change of circumstances warrant, we do not preclude prison authorities from establishing the need to override an inmate's choice to decline medical intervention. [citations omitted]. A custodial environment is uniquely susceptible to the catalytic effect of disruptive conduct; and courts will not interfere with reasonable measures required to forestall such untoward consequences. [citations omitted]. However, such measures must be demonstrably "reasonable" and "necessary," not a matter of conjecture. Id., 21 Cal.Rptr.2d at 370, 855 P.2d at 388.

Therefore, in analyzing the facts adduced in the particular case, the Thor court concluded that the record substantiated no countervailing state interest sufficient to override Andrews' right to self-determination. Id., 21 Cal.Rptr.2d at 372, 855 P.2d at 390.

[15] Turning to the instant case, quite obviously, the state interest in the preservation of life, the most significant interest, is implicated. Importantly, as noted in In re Browning, 568 So.2d 4 (Fla.1990). Costello's condition was curable rather than a
terminal affliction. However, although the state interest in the preservation of life is powerful, in and of itself, it will not foreclose a competent person from declining life-sustaining medical treatment. *Thor v. Superior Court*, 5 Cal. 4th 725, 21 Cal.Rptr.2d 357, 366, 855 P.2d 375, 384 (Cal. 1993). This is because the life that the state is seeking to protect is the life of the same person who has competently decided to forego the medical intervention. *Id.* The cases utilizing this interest to deny the continuation of a hunger strike have also discussed and found additional state interests implicated. Thus, considering the breadth of Florida's privacy right, the state's interest in the preservation of life, in and of itself, cannot overcome Costello's fundamental right to forego life-sustaining medical intervention.

Although Costello "set the death producing agent in motion" by engaging in a hunger strike, the state interest in the prevention of suicide is truly not implicated in the instant case. In the cases relying upon the prevention of suicide interest, the inmate actually desired the hunger strike to produce death. *In re Caulk*, 125 N.H. 226, 480 A.2d 93 (1984); *Von Holden v. Chapman*, 87 A.D.2d 66, 450 N.Y.S.2d 623 (1982). In the instant case, however, Costello testified that he did not want to die. Costello commenced his hunger strike as a form of protest, with the resolution of his complaints as the desired end. Thus, the purpose of the hunger strike was to bring about change, not death. Therefore, the state interest in the prevention of suicide is not implicated in the instant case.

The interest in the protection of innocent third parties is inapplicable in the instant case. This concern arises when the refusal of medical treatment endangers the public health or implicates the emotional or financial welfare of the patient's minor children. *Satz v. Perlmutter*, 362 So.2d 160, 162 (Fla. 4th DCA 1978), approved, 379 So.2d 359 (Fla. 1980); *Thor v. Superior Court*, 5 Cal.4th 725, 21 Cal.Rptr.2d 357, 371, 855 P.2d 375, 389 (Cal.1993). The death of a prison inmate serving a life sentence in no way endangers the public health. Additionally, there was no evidence of minor children depending emotionally or financially on Costello. Accordingly, the interest in the protection of innocent third parties is not implicated.

Likewise, no evidence was adduced in the instant case regarding the maintenance of ethical integrity of the medical profession. Moreover, as noted by the California supreme court, patient autonomy and medical ethics are not reciprocals; one does not come at the expense of the other. *Thor v. Superior Court*, 5 Cal.4th 725, 21 Cal.Rptr.2d 357, 368, 855 P.2d 375, 386 (1993). Rather, the latter is a necessary component and complement of the former and should serve to enhance rather than constrict the individual's ability to resolve a medical decision. *Id.* Thus, there is no threat to the interest in maintaining the ethical integrity of the medical profession, the least significant state interest, in upholding Costello's intelligent and conscious decision to forego medical intervention.

Lastly, because Costello is a prison inmate, the interest in maintaining an orderly and secure penal institution must be considered. In the instant case, however, the Appellants adduced no evidence that Costello's actions undermined the security, safety or welfare within the prison. There was no testimony that Costello has in any way caused a disruption or has posed as a security risk to the Martin County Correctional Institution. In the cases relying on this interest to deny the continuation of a hunger strike, evidence was present concerning the effect of the inmate's conduct upon the prison. See *5 Cal.4th 725, 21 Cal.Rptr.2d 357, 368, 855 P.2d 375, 386 (1993).* Obviously, a prison environment is uniquely susceptible to the "catalytic effect of disruptive conduct." *Thor v. Superior Court*, 5 Cal.4th 725, 21 Cal.Rptr.2d 357, 370, 855 P.2d 375, 388 (1993). However, in the instant case, arguments concerning the effect of Costello's conduct are nothing more than speculation and conjecture. See *Id.*

[16] Thus, in the instant case, Costello's privacy right to refuse medical intervention must be balanced against only the state interest in the preservation of life. This interest, in and of itself, cannot overcome the fundamental nature of Costello's privacy right. As such, the trial court did not err in determining that Costello, as a prison inmate, had the legal right to refuse medical treatment where the need for the treatment stemmed from a self-induced hunger strike. Accordingly, the trial court did not abuse its discretion in enjoining Appellants from providing Costello with any medical treatment or assistance while Costello engaged in a hunger strike.

Our resolution of this case should not be interpreted as universally holding that a prison inmate has the right to starve to death. Simply, under the facts of...
the instant case, the countervailing state interests did not overcome Costello's privacy right to refuse medical intervention. In another case, or with different evidence presented below, a different result may be reached. As previously mentioned, the various state interests to be considered ...

... are by no means a bright-line test, capable of resolving every dispute regarding the refusal of medical treatment. Rather, they are intended merely as factors to be considered while reaching the difficult decision of when a compelling state interest may override the basic constitutional right[s] of privacy...

*Public Health Trust of Dade County v. Wons, 541 So.2d 96, 97 (Fla.1989).* In the instant case, under the evidence adduced, the state interests did not override Costello's constitutional right of privacy.

AFFIRMED.

FARMER, J., and HENNING, PATTI ENGLANDER, Associate Judge, concur.

665 So.2d 1099, 21 Fla. L. Weekly D83

END OF DOCUMENT
Josephine SANGIUOLO, Plaintiff, v. Dr. Gerald LEVENTHAL and Dr. Jeffrey D. Postman, Defendants. - 132 Misc.2d 680, 505 N.Y.S.2d 507
June 30, 1986.

Upon doctor's motion for summary judgment, in medical malpractice action, the Supreme Court, New York County, Stanley L. Sklar, J., held that independent provider of medical care had obligation to inform patient of risks, benefits and alternatives to treatment he was going to administer while he was "covering" for original physician.

Summary judgment denied.

STANLEY L. SKLAR, Justice:

**508** *680* Ira H. Newman, New York City, for Sangiuolo.

Martin, Clearwater & Bell, New York City, for Leventhal.

Dwyer, Peltz & Walker by Eliot R. Clauss, New York City, for Postman.

Issue

Does a "substitute" physician, administering part of a course of treatment started by a physician for whom he is covering, have an obligation to advise of the risks, benefits and alternatives of that treatment? This court holds that the substitute has that obligation.

Facts

On January 30, 1978, Dr. Gerald Leventhal consulted with Ms. Josephine Sangiuolo concerning her complaints of joint pain which had been diagnosed as rheumatoid arthritis. A note appears in Dr. Leventhal's office records for that date reading: "Patient advised of possible Gold complications but agreeable to Rx." Plaintiff, however, asserts that Dr. Leventhal never told her of the risks of the proposed treatment.

On April 19, 1978, Dr. Leventhal started administering gold injections, utilizing the drug "Solgonal."

Dr. Jeffrey Postman, at the request of Dr. Leventhal, agreed to cover for Dr. Leventhal during his vacation. Dr. Postman saw Ms. Sangiuolo on June 29, July 6, July 11 and July 17, 1978.

On June 29, Dr. Postman saw her in his office, inquired about her condition, did a urinalysis, which was read as normal, drew blood for a CBC analysis and administered Solgonal. The CBC analysis was later reported as normal.

On July 6, Dr. Postman administered another injection, and did another urinalysis, which was read as normal. On July 11, Ms. Sangiuolo complained of a rash, and Dr. Postman told her the gold therapy must stop, did not administer any further injections, treated her with physician, as independent provider of medical care, had duty to inform patient of benefits and alternatives to treatment administered, that duty could be found to have been met by original physician.

several medicines and drew blood for a CBC analysis, which was again ultimately read as normal.

On July 17, Dr. Postman saw her again for an examination and he adjusted her medication. He never saw her again.

The Claims

Defendant Postman seeks summary judgment, urging that there is no genuine issue of material fact as to the two theories advanced by plaintiff to hold him liable. He is correct as to the first, actual malpractice, and in error as to the second, informed consent.

Malpractice

Plaintiff admits that gold injection therapy is an accepted method of treatment of rheumatoid arthritis. However, she claims that Dr. Postman was negligent in not taking blood for a CBC analysis on July 6, and that such failure was a proximate cause of her severe skin rash. She errs. Defendant claims that a CBC analysis every two weeks was in accordance with good and accepted standards of medical care. However, even if he were in error, the failure to take blood on July 6 could not have been a proximate cause of plaintiff's rash because the CBC analysis of the blood taken on June 29 was normal, so that he was justified in giving the July 6 injection. The next time he saw plaintiff, the rash had already appeared, and he did not administer any further injections.

Informed Consent

Dr. Postman insists that he relied upon, and was entitled to rely upon the notation in Dr. Leventhal's chart that Leventhal had advised plaintiff of the possible gold treatment complications, but she nonetheless agreed to proceed. However, a genuine issue of fact is presented in these papers as to whether or not Dr. Leventhal in fact **509 advised Ms. Sanguiuolo of the risks of the proposed gold therapy.

The landmark case of Salgo v. Stanford University Board of Trustees, 154 Cal.App.2d 560, 578, 317 P.2d 170, 181, declared that a "physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the bases of an intelligent consent by the patient to the proposed treatment." Emphasizing the word proposed in the Salgo doctrine, Dr. Postman claims that it was only Dr. Leventhal who had a duty to advise Ms. Sanguiuolo of the risks of gold therapy. He urges that this is true because the course of treatment was determined by Dr. Leventhal and he, Dr. Postman, was only following that course. He buttresses the argument by reference to New York decisions which also speak of the obligation to advise of the risks of the proposed treatment. See, e.g., Garone v. Roberts' Trade School, 47 A.D.2d 306 at 317, 366 N.Y.S.2d 129. He even cites one gold therapy case in which the court held that the doctor "was obligated to make reasonable disclosure to his patient of the known dangers which were incident to or possible in the proposed use of gold ..." Di Rosse v. Wein, 24 A.D.2d 510, 261 N.Y.S.2d 623.

However, closer analysis of the informed consent doctrine *683 and of the cases interpreting it reveals that Dr. Postman proceeded at his peril in relying on an entry of another doctor without himself apprising Ms. Sanguiuolo of the risks of gold therapy.

Justice Cardozo stated in Schoendorff v. Society of N.Y. Hospital, 211 N.Y. 125, 129, 105 N.E.2d 92, that "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." The doctrine has been incorporated in § 2805-d(1) Public Health Law (effective in 1975), which says:

"Lack of informed consent means the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation."

This statute, which governs this 1976 incident, speaks of the necessity for the person providing the treatment to make disclosure to the patient.

The cases relied on by defendant are inapposite. So, in Fiorentino v. Wenger, 19 N.Y.2d 407 at 417, 280 N.Y.2d 373, 227 N.E.2d 296, the Court of Appeals held only that a hospital is not liable for lack of informed consent by a surgeon unless the hospital had reason to know that the patient was unaware of the dangers. Nisenholtz v. Mount Sinai Hosp., 126 Misc.2d 658 at 663, 483 N.Y.S.2d 568, held that a physician who only refers a patient to another doctor does not become liable if the second doctor performs surgery without informed consent. See also: Prooth v. Wallsh, 105 Misc.2d 603 at 606, 432 N.Y.S.2d 663; Graddy v. New York Medical College, 19 A.D.2d 426, 243 N.Y.S.2d 940.

The Prooth case analyzed the informed consent doctrine as being grounded either in nonconsensual...
touching of the body akin to assault and battery (citing Schloendorff), or in the more recent rationale of constituting a variety of medical malpractice. [FN*] The Prooth court said that the duty to inform must be limited on either theory. If on the nonconsensual touching theory, only the party actually touching the body or directing such touching should be liable; if on the malpractice theory, every participant in a procedure may be liable to explain the particular risks of his phase of the treatment but not, necessarily, to explain the risks of another participant's treatment.

FN* The failure to secure a patient's informed consent is generally now regarded as a "species of malpractice" and is, accordingly, governed by the two and one-half years malpractice statute of limitations. CPLR § 214-a; R. Shaiedell, The Preparation and Trial of Medical Malpractice Cases 5-11 (1981). See also: Murriello v. Crapotta, 51 A.D.2d 381, 382 N.Y.S.2d 513. An action involving no consent at all may sound in assault and battery.

**510 [1] The New York courts, and courts of other states, have considered the relationship between the original treating physician and the substitute, in deciding whether the referring physician is liable for malpractice of the substituting doctor. See, e.g. Impastato v. DeGirolamo, 117 Misc.2d 786, 459 N.Y.S.2d 512; Prooth v. Wallsh, supra; Graddy v. New York Medical College, supra; Moulton v. Huckleberry, 150 Ore. 538, 46 P.2d 589. A substantial number of factors have been considered in determining what the relationship between the two physicians is, whether master-servant, independent practitioners, etc. In Impastato v. DeGirolamo, 117 Misc.2d 786 at 790-91, 459 N.Y.S.2d 512, the court noted that control is a most important factor in deciding whether the relationship is master-servant. In the instant case, although invited to explore the relationship, the parties do not claim that there is any special relationship between Drs. Leventhal and Postman. We know only that the two doctors have offices in the same building and that Ms. Sangiuolo made payments directly to Dr. Postman. The assumption must therefore follow that Dr. Postman was an independent treating physician. Accordingly, the caveat in Prooth, regarding even the nonconsensual touching theory of failure to secure informed consent, that only the person touching or directing the touching should be liable, does not aid Dr. Postman.

[2] Neither counsel nor the court have found any American case on the issue of the liability of the substituting physician to provide informed consent. However, the rationales that have been considered to underly the informed consent doctrine mandate this court's holding that Dr. Postman, as an independent provider of medical care, had the obligation to inform Ms. Sangiuolo of the risks, benefits and alternatives to the treatment that he was going to administer.

Nor am I persuaded that a different holding is required by Dr. Postman's arguments that (1) he was entitled to rely on Dr. Leventhal's note, and (2) this holding will make it more difficult for vacationing doctors to secure substitutes.

[3] As to the entitlement to rely argument, if Dr. Postman had no duty to inform, then it does not matter whether or not he relied. However, although he had the duty to inform, that duty may be found to have been met by Dr. Leventhal. If, at trial, it is determined that Dr. Leventhal appropriately warned Ms. Sangiuolo of the risks of the gold therapy, Dr. Postman will be a beneficiary of that finding. If the finding is one of a lack of informed consent then, as noted above, Dr. Postman will have relied on Dr. Leventhal's entry at his peril. The issue must await trial.

Dr. Postman's final argument that the imposition of liability on a substituting doctor will make it more difficult for physicians to find others to cover for them is unrealistic. Most "covering" situations involve handling whatever new problems arise, and the covering physician's duty to inform with respect to new problems is unaffected. Furthermore, the burden of advising of the risks of a continuing course of treatment is minimal.

Summary judgment is accordingly denied.

132 Misc.2d 680, 505 N.Y.S.2d 507

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Supreme Court, Appellate Division, First Department, New York

July 22, 1982
SUMMARY
Appeal from a judgment of the Supreme Court in favor of plaintiff, entered February 13, 1981, in New York County, upon a verdict rendered at a Trial Term (Michael J. Dontzin, J.).

HEADNOTES
Physicians and Surgeons--Malpractice
(1) Plaintiff, who has been blind since infancy as a result of his prolonged exposure to concentrated levels of oxygen following his premature birth in 1953, presented sufficient evidence to support a medical malpractice award against the prescribing physician and the hospital where he was treated, on the ground that they failed in their duty of care to plaintiff; although the conventional medical wisdom at the time was that increased oxygen was essential to the survival of premature babies, both defendants, who were then involved in a major study on this method of treatment, were aware of the dangers of excess oxygen, and knew or should have known that plaintiff was progressing well in the curtailed oxygen environment ordered by the child's treating physician. Moreover, the evidence presented established a practice at the time of plaintiff's treatment to obtain the informed consent of a patient prior to treatment and that defendants failed to do so, which was sufficient to support the verdict against defendants on the basis of a failure to obtain informed consent; however, inasmuch as the treating physician did not prescribe the increased oxygen and no evidence was offered of any continuing obligation on his part to obtain informed consent once his order was countermanded by a superior, the verdict against him, which was based solely on a failure to obtain informed consent, is reversed.

Damages--Inadequate and Excessive Damages--Medical Malpractice Award
(2) In a medical malpractice action for injuries sustained by plaintiff, who has been blind since infancy as a result of his prolonged exposure to concentrated levels of oxygen following his premature birth, a verdict awarding plaintiff $2,887,000 is disproportionate to his damages to the extent that it exceeds $1,500,000.

APPEARANCES OF COUNSEL
Richard J. Concannon of counsel (Kathleen M. Burke and Geraldine M. Boylan with him on the brief; Kelley Drye & Warren, attorneys), for appellants.

Emilio Nunez of counsel (Mark B. Wiesen with him on the brief; Mark B. Wiesen, P. C., attorney), for respondent.

OPINION OF THE COURT
Sullivan, J.

Plaintiff, blind since infancy from a disease known as retrolental fibroplasia (RLF), caused by his exposure to a prolonged liberal application of oxygen, has recovered a substantial judgment for medical malpractice against New York Hospital, where he was treated as a premature infant, and two of its physicians, all of whom appeal.

Born five to six weeks premature at Brooklyn Doctors Hospital on July 3, 1953, plaintiff, who weighed only 1,362 grams or three pounds at birth, was transferred the next day to New York Hospital, which had been designated by the City of New York as a premature nursery care center. Transfer was automatic in cases where an infant weighed less than 1,500 grams. At the time, more than half of all premature babies of plaintiff's size died in infancy; many of the survivors either sustained brain damage or were blinded by RLF, a disease which, first identified in 1942, reached epidemic proportions in this country in the late 1940's and early 1950's. The increase in the incidence of RLF coincided with the widespread advances in the development of lifesaving techniques in treating premature infants, all of which revolved around the liberal use of oxygen.

RLF is a progressive disease consisting of five stages. Initially, the blood vessels to the retina constrict. In the second stage the vessels enlarge, causing hemorrhaging into the retina. Further bleeding into the inside of the eye develops in the third stage, and in the fourth a localized tear in the retina ("retinal detachment") occurs. Finally, the retina detaches and a fibroid mass develops over the crystalline lens of the eye. The disease is irreversible in the fourth and fifth stages.

In the summer of 1953 a significant segment of the
medical community continued to believe that the liberal administration of oxygen to premature babies was important in preventing death or brain damage. Yet, a respected body of medical opinion believed that oxygen contributed to RLF. Thus, the medical profession was confronted with a terrible dilemma -- the antidote to two problems, death and brain damage, appeared to be the cause of another, blindness. One court, commenting on the perplexity of the problem, spoke of the anxiety of those physicians who "tried to steer their tiny patients between the Scylla of blindness and the Charybdis of brain damage." (May v. Dafoe, 25 Wn App 575, 576.)

On July 1, 1953, just two days before plaintiff's birth and after years of uncoordinated and inconclusive independent investigation, a national human research study known as the Cooperative Study of Retrolental Fibroplosia and the Use of Oxygen (Cooperative Study) was undertaken in an attempt to determine the role of oxygen in RLF and the effect of its withdrawal or curtailment. The Cooperative Study, whose conclusions were announced on September 19, 1954 and published in October of 1956, found that prolonged liberal use of oxygen was the critical factor in the development of RLF, and that curtailment of the supply of oxygen to premature infants after 48 hours to clinical need decreased the incidence of RLF without increasing the risk of death or brain damage.

While liberal exposure to oxygen continued to be routine treatment for premature babies at the time of plaintiff's birth, the view that increased oxygen was a necessary life savior had, as already noted, become suspect. New York Hospital, for instance, had, from January, 1952 to June, 1953, conducted its own study of the effects of oxygen on premature infants and concluded "that prolonged oxygen therapy may be related to the production of RLF". The results of that 18-month study were announced by the hospital on June 16, 1953 at a meeting attended by its pediatricians and ophthalmologists. Because the preliminary results of its investigation were considered to be insufficient, however, the hospital decided to become a participant in the Cooperative Study. This was the situation that existed on July 4, 1953 when plaintiff entered New York Hospital.

At the time of his transfer plaintiff's condition was recorded as "good" and, except for his prematurity, no abnormal conditions were noted. From the time of birth until his arrival at New York Hospital around noon, he was being administered four liters of oxygen continuously. Upon his arrival he was placed under the care of Dr. Lawrence Ross, a pediatric resident, who examined him and found his condition "good, his color pink, cry vigorous and clear lungs throughout." He concluded that plaintiff was "a vigorous premature infant, in good condition with no abnormalities or anomalies (sic)." A loss of 62 grams in his weight was noted, however, and plaintiff was placed on the "serious list". Dr. Ross directed that plaintiff be placed in an incubator with oxygen at three to four liters. At 11:15 that evening Dr. Ross, aware that oxygen had been implicated as a cause of RLF, ordered that oxygen be "reduced ... as tolerated." Dr. Ross testified that the order to reduce oxygen was "good medical practice and in accordance with [my] judgment". The following day he noted that plaintiff appeared "to be doing well."

The hospital records indicate that, in compliance with Dr. Ross' order, the nurses did reduce the oxygen flow from three to two and one-half liters, and the concentration of oxygen in the incubator from 35% to 30%. Plaintiff's condition throughout remained good, and no problems necessitating an increase in the oxygen flow were reported.

On July 6 at 2:10 p.m., Dr. Mary Engle, a member of the hospital staff and an instructor in pediatrics at New York Hospital's affiliate, the Cornell University Medical College, on instructions from Dr. Levine, the Chairman of the Department of Pediatrics, entered an order in the hospital record, "Oxygen study: In prolonged oxygen at concentration greater than 50%." At the time Dr. Engle was serving as Dr. Levine's assistant for purposes of co-ordinating the hospital's participation in the Cooperative Study. Dr. Engle conceded that she countermanded Dr. Ross' order without examining plaintiff and without ever speaking to his parents. She testified further that she had no responsibility for the care and treatment of premature infants or the supervision of residents.

The Cooperative Study's methodology was to enter and observe premature babies at or less than 1,500 grams or less at birth after 48 hours. Its protocol provided that one out of every three such premature infants be placed in an increased oxygen environment, while two out of three be placed in reduced oxygen. This method of distribution was designed to subject the least number of babies to the risk of blindness that statistics would permit. Of the approximately 760 babies who were placed in the study throughout the United States, only 68 were placed in increased oxygen. As a result of Dr. Engle's order the concentrations of...
oxygen went from two and one-half to five liters in one day, and, over a span of 28 days in increased dosages up to a high of nine liters, and from an environment of 30% oxygen to a high of 82%. Dr. Engle testified that at the time of plaintiff's birth the medical community was unsure whether premature babies were better or worse off in routine (increased) oxygen, but conceded that the doctors familiar with the earlier New York Hospital study, of which she was a co-author, had concluded that increased oxygen might be unnecessary for premature babies. Nevertheless, she stated, prolonged oxygen was the routine practice. New York Hospital's manual on the "Management of Premature Infants", which set forth the hospital's rules relating to premature care, provided for the liberal administration of oxygen.

On two or three occasions during the 28-day high oxygen state, ophthalmoscopic examinations were performed on plaintiff's eyes. On July 6 the media, that is, the fluid and tissue inside the eyes, were diagnosed as hazy. Plaintiff's expert testified that such a condition was abnormal in any baby, regardless of the weight. On July 22 and 29 the optical media were again diagnosed as hazy. On August 5, after plaintiff had been removed from his high oxygen environment, a fourth examination showed a large hemorrhage in the right eye, dilation and distortion of the blood vessels. The bleeding was entering the media and some scarring of the retina was evident. On August 12 another examination revealed several hemorrhages in the right eye, as well as swelling and the collection of fluid. The left eye manifested similar conditions. On August 19 a final examination before discharge revealed that the swelling had totally enveloped the eyes.

Except for faint light perception in his left eye plaintiff is totally blind. He suffers daily pain and irritation, which has worsened in recent years and which he eases by rubbing and pressing his eyes. Except for a brief stint in his family's business answering phones, and a part-time job as an interviewer with the Blind Guild he has been unable to find employment. Eventually, because his eyes are shrinking, they will have to be enucleated and replaced with plastic ones.

In 1975 plaintiff commenced this action against New York Hospital, Dr. Ross and Dr. Engle, alleging medical malpractice and the failure to obtain informed consent from his parents before placing him in an increased oxygen environment. The jury absolved Dr. Ross from liability for malpractice, but found him liable for failing to obtain informed consent. New York Hospital and Dr. Engle were found liable under both theories.

Plaintiff's proof clearly established that the prolonged liberal administration of oxygen to which he was subjected caused his blindness, and defendants do not challenge this finding. Since 1954 prolonged exposure to oxygen has been uniformly recognized as the leading cause of RLF. Of the several issues raised defendants' principal contention, as it was at trial, is that the treatment which plaintiff received at New York Hospital was in accordance with applicable 1953 community standards. The question presented to the jury was whether defendants followed sound medical practice in 1953 in permitting plaintiff to be exposed to an increased oxygen environment for a prolonged period, even though it was a common practice at the time, when they were aware of the possibility that RLF might result. Ancillary to that question was whether, even if defendants exercised proper medical judgment, they should have informed plaintiff's parents of the risks involved, and obtained their consent.

We believe that the evidence supports a finding that Dr. Engle and the hospital failed in their duty to plaintiff in both respects, and, thus, the verdict of liability against them should stand. We further find that Dr. Ross, who did not order the increase in oxygen, and whose own order to reduce oxygen was countermanded, should not have been found liable at all.

Any analysis of defendants' liability must take into account that when plaintiff arrived at New York Hospital he was a healthy baby, without any unusual conditions, except that he was premature and had lost some weight, a not atypical postbirth phenomenon. The treating resident, Dr. Ross, initially placed him in a higher than average oxygen environment, as was common practice at the time, but, recognizing the baby's good health, directed that the oxygen be reduced as tolerated. Yet, Dr. Engle, who was not plaintiff's physician, and who admitted that she had neither examined the baby nor had any responsibility for the care of premature infants, changed the oxygen supply and ordered a drastic increase. No adverse change in the baby's medical condition had been noted at the time. He was
progressing well, and indicated no need for additional oxygen. Thus, it seems reasonably clear that Dr. Engle's order to increase the oxygen supply was an administrative judgment, based upon a random allocation of babies into one of two groups for monitoring as part of the Cooperative Study. Neither the hospital nor Dr. Engle offered any medical reason for placing plaintiff in routine (increased) oxygen. Both Dr. Engle and the hospital were aware of the dangers of excess oxygen, and, more importantly, knew or were charged with the knowledge that plaintiff was progressing well in a curtailed oxygen environment.

Although the conventional medical wisdom at the time believed that increased oxygen was essential to the survival of premature babies, the hospital and Dr. Engle cannot avail themselves of the shield of acceptable medical practice when a number of studies, including their own, had already indicated that increased oxygen was both unnecessary and dangerous, particularly for an otherwise healthy baby, and especially when the attending physician, who had primary responsibility for the patient's health, had recommended a decrease. "[A] physician should use his best judgment and whatever superior knowledge, skill and intelligence he has". (Toth v Community Hosp. at Glen Cove, 22 NY2d 255, 262.) Moreover, "his judgment must be founded upon his intelligence." (DuBois v Decker, 130 NY 325, 330; see, also, Pigno v Bunim, 43 AD2d 718; Cunningham v State of New York, 10 AD2d 751.)

Furthermore, the jury had before it evidence that symptoms of RLF had begun to appear during the 28-day period *224 of increased oxygen. Yet, the hospital permitted a healthy infant to remain in a precarious position after symptoms of a disease of which it was aware and, indeed, was studying, had been detected. Thus, the jury could find that even if the hospital had been justified in placing plaintiff in increased oxygen, it should have removed him from the high oxygen environment long before it did because of the results of the periodic ophthalmoscopic examinations.

Moreover, that increased oxygen was the only accepted practice at the time of the study is belied by the hospital's own involvement in the Cooperative Study. Two out of three premature babies were given curtailed oxygen, while only one out of three was placed in increased oxygen. Thus, by testing two out of three babies, the hospital was acting contrary to its own routine. Without in any way challenging the legitimacy of the debate within the medical community as to the effect of the curtailment of oxygen on premature infants, we find it difficult to believe that any reputable institution would permit two out of three of its patients to receive unusual treatment, which might result in death or brain damage, unless it was fairly convinced that the conventional wisdom no longer applied.

Since compelling evidence was introduced that New York Hospital and Dr. Engle, whatever their uncertainty, were aware that plaintiff's life would not have been jeopardized if Dr. Ross' order to reduce oxygen had been followed, and of the risk of blindness inherent in the high oxygen environment which they ordered, the jury's finding of malpractice should not be disturbed. The issue was submitted to the jury under a proper charge. "If a physician fails to employ his expertise or best judgment, and that omission causes injury, he should not automatically be freed from liability because in fact he adhered to acceptable practice." (Toth v Community Hosp. at Glen Cove, 22 NY2d, at p 263.)

In the factual context in which it is presented, the issue of informed consent is, to an extent, virtually inseparable from the malpractice question. Both parents testified that they were unaware that their child had been placed in a study concerning the effects of oxygen on RLF or of Dr. *225 Engle's order directing that their baby receive prolonged, high concentrations of oxygen. Plaintiff's father testified that he was given a consent form from a nurse which he signed without any elaboration or elucidation as to the risks of the treatment plaintiff was to receive. The consent was general in nature and authorized "the doctors of the New York Hospital to give such treatment and medication to my son which in their judgment becomes necessary while he is a patient in the New York Hospital." In the consent plaintiff's father also waived all claim to prior notification of any treatment. As was customary at the time the consent form itself did not recite any of the risks involved or indeed that the individual signing it had ever been apprised of the existence of such risks.

Defendants contend that in 1953 no legal duty to obtain informed consent based upon broad disclosure of the proposed procedure, its risks and other factors existed in New York or, for that matter, in any other State; and that the doctrine of informed consent was not recognized in New York until 1965. Although the law on informed consent in 1953 was not as explicit as it is today, nor the procedures as refined, Dr. Engle testified that it was the hospital's practice, quite apart

from any written consent, to have the house officer or resident, in this case Dr. Ross, inform a patient's parents of all the risks involved and the options available before any patient was put into an experimental study. Dr. Ross, however, had no recollection as to whether he told plaintiff's parents of the risks involved. Plaintiff's expert, Dr. Abramson, although not a physician in 1953, stated that the practice for "centuries" had been to inform patients of the type and risks of treatment, and to obtain their consent.

While the law in New York at that time did not require the detailed imparting of information such as has been statutorily mandated since 1975, either with respect to treatment (Public Health Law, § 2805-d, subd 1) or the conduct of research (Public Health Law, § 2442), doctors were never free to expose their patients to unwarranted risks without first obtaining their consent. As the Court of Appeals noted in 1914 in *Schloendoff v Society of New York Hosp.* (211 NY 125, 129), "[e]very human being of *226* adult years and sound mind has a right to determine what shall be done with his own body". Defendants argue that this case stands only for the proposition that a surgeon may not operate on a patient without his or her consent, and that it did not place an affirmative duty upon a physician to explain all the risks involved in a course of treatment. Yet, even Dr. Engle viewed a doctor's duty to his patients as more than merely an obligation to refrain from treatment to which a patient had not consented.

The 1965 case which defendants claim created the informed consent doctrine in New York, *Di Rosse v Wein* (24 AD2d 510), does not appear to have been viewed by the court which wrote the decision as imposing upon doctors and hospitals a previously unknown duty. Rather, it appears merely to have recognized the responsibilities of a physician, as they already existed. Because a New York court was not squarely confronted with the issue until 1965 does not mean that the duty did not exist before then. Moreover, in *Salgo v Leland Stanford, Jr. Univ. Bd. of Trustees* (154 Cal App 2d 560), a 1957 case in which defendants claim the doctrine was first enunciated by an American court, the language is equally devoid of any precedent-setting quality. In stating (p 578) that "[a] physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment", the court in no way intimated that it was imposing on physicians an obligation which was not already known to exist.

Thus, in the absence of a New York case rejecting the doctrine of informed consent before 1965, or at least limiting a doctor's liability where he has received a general consent from his patient, we find that the practice at the time of plaintiff's treatment, as testified to by Dr. Engle and Dr. Abramson, was sufficient to establish the duty.

Whether the hospital followed its own practice, and informed plaintiff's parents of the risks involved was, of course, a question of fact for the jury. Its finding is supported by the record since Dr. Ross, upon whom the hospital imposed the duty to inform the Burtons, could not recall doing so, while plaintiff's parents testified that neither had *227* been informed of any study or of any of the risks. Inasmuch as Dr. Ross did not prescribe the increased oxygen, however, and no evidence was offered of any continuing obligation on his part to obtain informed consent once his order was countermanded by a superior, the verdict against him based on failure to obtain informed consent cannot stand.

One other issue raised warrants comment. New York Hospital argues that it cannot be charged with liability for events occurring in July-August, 1953, because of the doctrine of charitable immunity, which, although subsequently abolished in 1957 by *Bing v Thunig* (2 NY2d 656), was then alive and well (see, e.g., *Mrachek v Sunshine Biscuit*, 308 NY 116). This issue was never raised in a pleading or at trial. Without deciding whether we should reach an issue raised for the first time on appeal, as well as considering both the retroactive effect of *Bing* on cases not yet tried and the applicability of the immunity doctrine, that is "whether the injury-producing act was 'administrative' or 'medical'" (see *Bing v Thunig*, 2 NY2d, at p 658), we note that the malpractice in *Bing* occurred on June 3, 1953, which was before plaintiff's birth. Thus, the *Bing* ruling is directly applicable to this case.

(2) We have examined defendants' other contentions and find that they are without merit, except that we agree that the damage award of $2,887,000 is disproportionate to plaintiff's damages, to the extent that it exceeded $1,500,000.

Accordingly, the judgment, Supreme Court, New York County (Dontzin, J.), entered February 13, 1981, in favor of plaintiff in the sum of $2,887,000, should be reversed, on the law, without costs or disbursements, and the complaint dismissed as to defendant Dr. Lawrence S. Ross, and modified, on
the law and on the facts, as to defendants New York Hospital and Dr. Mary Allen English Engle, to the extent of reversing the judgment in favor of plaintiff and ordering a new trial on the issue of damages only, without costs or disbursements, unless plaintiff, within 20 days after service of a copy of the order to be entered herein, with notice of entry, serves and files in the office of the clerk of the trial court, a written stipulation consenting to reduce the verdict in his favor to $1,500,000 and to the *228 entry of an amended judgment in accordance therewith. If plaintiff so stipulates, the judgment as so amended and reduced, is affirmed as to defendants New York Hospital and Dr. Engle, without costs or disbursements.

Kupferman, J. P., Sandler, Silverman and Asch, JJ., concur.

Judgment, Supreme Court, New York County, entered on February 13, 1981, unanimously reversed, on the law, without costs and without disbursements, and the complaint dismissed as to defendant Dr. Lawrence S. Ross, and modified, on the law and on the facts, as to defendants New York Hospital and Dr. Mary Allen English Engle, to the extent of reversing the judgment in favor of plaintiff and ordering a new trial on the issue of damages only, without costs and without disbursements, unless plaintiff, within 20 days after service of a copy of this court's order, with notice of entry, serves and files in the office of the clerk of the trial court, a written stipulation consenting to reduce the verdict in his favor to $1,500,000 and to the entry of an amended judgment in accordance therewith. If plaintiff so stipulates, the judgment as so amended and reduced, is affirmed as to defendants hospital and Dr. Engle, without costs and without disbursements. *229

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BURTON V BROOKLYN HOSP

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Dorrence Kenneth DARLING, II, Appellee, v. CHARLESTON COMMUNITY MEMORIAL HOSPITAL, Appellant. - 33 Ill.2d 326, 211 N.E.2d 253, 14 A.L.R.3d 860

No. 38790.


Action brought on behalf of minor by father to recover damages for allegedly negligent medical and hospital treatment which necessitated leg amputation. Prior to trial action was dismissed as to doctor. The jury returned verdict against hospital, and judgment was entered accordingly by the Circuit Court of Coles County, Robert F. Cotton, J. Judgment was affirmed by Appellate Court for Fourth District, 50 Ill.App.2d 253, 200 N.E.2d 149, and hospital appealed. The Supreme Court, Schaefer, J., held that hospital could not limit its liability as a charitable corporation to amount of its liability insurance, that evidence supported verdict, and that other contentions and objections of hospital gave no ground for reversal.

Affirmed.

West Headnotes

[1] Negligence 236

(Formerly 272k) Custom should never be conclusive in determining standard of care but is relevant because it illustrates what is feasible, it suggests a body of knowledge of which defendant should be aware, and it warns of possibility of far-reaching consequences if higher standard is required.

[2] Health 820

(Formerly 204k Hospitals) Evidence relating to hospital's alleged failure to require proper nursing care and consultation or examination by specialists was sufficient to support verdict for patient suing on amputation necessitated by gangrene in broken leg.


An entire verdict is not to be set aside because one asserted ground of recovery was defective or inadequately proven, if one or more grounds are sufficient, unless motion to withdraw issue in question was made. S.H.A. ch. 110, § 68(4).

[4] Health 823(7)

Evidence relating to hospital's alleged failure to require proper nursing care and consultation or examination by specialists was sufficient to support verdict for patient suing on amputation necessitated by gangrene in broken leg.

[5] Pleading 245(3)

Hospital being sued by patient for personal injury was not unfairly surprised by amendment to patient's complaint relating to customary hospital standards and made at close of patient's case where amendment did not change theory of case and where patient had filed memorandum at pretrial conference more than 5 months before trial which stated theory which hospital contended was new at time of amendment.


(Formerly 157k) It was not error for trial court in personal injury action by patient against hospital to permit cross-examination of hospital's expert witnesses concerning views of recognized authorities in their field, even though witnesses did not purport to base their opinions on views of these authorities.

[7] Evidence 15

(Formerly 157k) An author's competence as an expert is established if judge takes judicial notice of it, or if it is established by a witness expert in subject.

[8] Charities 45(2)

Charitable corporations cannot limit their liability for
torts to amount of their liability insurance.

[9] Health 830
198k830 Most Cited Cases
(Formerly 204k7 Hospitals)
Hospital sued by patient for negligence in causing personal injury could not limit liability to amount of liability insurance carried by hospital.

[10] Courts 100(1)
106k100(1) Most Cited Cases
Aspect of decision in favor of patient suing hospital for personal injury which overruled doctrine of charitable immunity from liability for torts for more than amount of liability insurance, in view of fact that doctrine might have been relied upon by charitable corporations in deciding whether to carry insurance and amount of insurance, was given prospective effect only, except as to patient in instant case.

30k1052(1) Most Cited Cases
Error in admitting evidence in patient's personal injury suit against hospital which suggested misleading inferences from fact that several patients under staff doctor's care had died was not sufficiently prejudicial to warrant reversal, where explanatory information was supplied on redirect examination.

[12] Appeal and Error 1078(4)
30k1078(4) Most Cited Cases
Objections of hospital to instructions in personal injury suit by patient were not waived on appeal because the objectionable instructions were not set out at length in hospital's brief.

30k1064.1(8) Most Cited Cases
(Formerly 30k1064(1))
Instructions in patient's personal injury suit against hospital which stated certain hospital bylaws and accreditation regulations and answers to certain interrogatories did not give prejudicial emphasis to any evidence.

[14] Health 827
198k827 Most Cited Cases
(Formerly 204k8 Hospitals)
It was not error in patient's personal injury suit against hospital to refuse to instruct jury that customary standards of community establish duty of hospital.

[16] Health 827
198k827 Most Cited Cases
(Formerly 204k8 Hospitals)
It was not error in patient's personal injury suit against hospital to give any instruction which indicated it was duty of hospital to supervise competence of staff members.

[17] Trial 129
388k129 Most Cited Cases
Where counsel for both parties in patient's personal injury suit against hospital indulged in improper argument, the court could not say that improprieties on one side outweighed those on the other.

*327 **255 Jack E. Horsley and John P. Ewart, of Craig & Craig, Mattoon (Wayne O. Shuey, Charleston, and Fred H. Kelly, Mattoon, of counsel), for appellant.

Stanford S. Meyer, Belleville, and John Alan Appleman, Urbana, for appellee.

*328 SCHAEFER, Justice.

This action was brought on behalf of Dorrence Darling II, a minor (hereafter plaintiff), by his father and next friend, to recover damages for allegedly negligent medical and hospital treatment which necessitated the amputation of his right leg below the knee. The action was commenced against the Charleston Community Memorial Hospital and Dr. John R. Alexander, but prior to trial the action was dismissed as to Dr. Alexander, pursuant to a covenant not to sue. The jury returned a verdict against the hospital in the sum of $150,000. This amount was reduced by $40,000, the amount of the settlement with the doctor. The judgment in favor of the plaintiff in the sum of $110,000 was affirmed on appeal by the Appellate Court for the Fourth District, which granted a certificate of importance. 50 Ill.App.2d 253, 200 N.E.2d 149.

On November 5, 1960, the plaintiff, who was 18 years old, broke his leg while playing in a college football game. He was taken to the emergency room at the defendant hospital where Dr. Alexander, who was on emergency call that day, treated him. Dr. Alexander, with the assistance of hospital personnel,
applied traction and placed the leg in a plaster cast. A heat cradle was applied to dry the cast. Not long after the application of the cast plaintiff was in great pain and his toes, which protruded from the cast, became swollen and dark in color. They eventually became cold and insensitive. On the evening of November 6, Dr. Alexander 'notched' the cast around the toes, and on the afternoon of the next day he cut the cast approximately three inches up from the foot. On November 8 he split the sides of the cast with a Stryker saw; in the course of cutting the cast the plaintiff's leg was cut on both sides. Blood and other seepage were observed by the nurses and others, and there was a stench in the room, which one witness said was the worst he had smelled since World War II. The plaintiff remained *329 in Charleston Hospital until November 19, when he was **256 transferred to Barnes Hospital in St. Louis and placed under the care of Dr. Fred Reynolds, head of orthopedic surgery at Washington University School of Medicine and Barnes Hospital. Dr. Reynolds found that the fractured leg contained a considerable amount of dead tissue which in his opinion resulted from interference with the circulation of blood in the limb caused by swelling or hemorrhaging of the leg against the construction of the cast. Dr. Reynolds performed several operations in a futile attempt to save the leg but ultimately it had to be amputated eight inches below the knee.

The evidence before the jury is set forth at length in the opinion of the Appellate Court and need not be stated in detail here. The plaintiff contends that it established that the defendant was negligent in permitting Dr. Alexander to do orthopedic work of the kind required in this case, and not requiring him to review his operative procedures to bring them up to date; in failing, through its medical staff, to exercise adequate supervision over the case, especially since Dr. Alexander had been placed on emergency duty by the hospital, and in not requiring consultation, particularly after complications had developed. Plaintiff contends also that in a case of fracture of the leg the duty of the hospital staff to see that these procedures were followed, and that either the nurses were derelict in failing to report developments in the case to the hospital administrator, he was derelict in bringing them to the attention of the medical staff, or the staff was negligent in failing to take action.

Defendant is a licensed and accredited hospital, and the plaintiff contends that the licensing regulations, accreditation standards, *330 and its own bylaws define the hospital's duty, and that an infraction of them imposes liability for the resulting injury.

The defendant's position is stated in the following excerpts from its brief: 'It is a fundamental rule of law that only an individual properly educated and licensed, and not a corporation, may practice medicine. * * * Accordingly, a hospital is powerless under the law to forbid or command any act by a physician or surgeon in the practice of his profession. * * * A hospital is not an insurer of the patient's recovery, but only owes the patient the duty to exercise such reasonable care as his known condition requires and that degree of care, skill and diligence used by hospitals generally in that community. * * * Where the evidence shows that the hospital care was in accordance with standard practice obtaining in similar hospitals, and Plaintiff produces no evidence to the contrary, the jury cannot conclude that the opposite is true even if they disbelieve the hospital witnesses. * * * A hospital is not liable for the torts of its nurse committed while the nurse was but executing the orders of the patient's physician, unless such order is so obviously negligent as to lead any reasonable person to anticipate that substantial injury would result to the patient from the execution of such order. * * * The extent of the duty of a hospital with respect to actual medical care of a professional nature such as is furnished by a physician is to use reasonable care in selecting medical doctors. When such care in the selection of the staff is accomplished, and nothing indicates that a physician so selected is incompetent or that such incompetence should have been discovered, more cannot be expected from the hospital administration.'

The basis dispute, as posed by the parties, centers upon the duty that rested upon the defendant hospital. That dispute involves the effect to be given to evidence concerning the community standard of care and diligence, and also the *331 effect to be given to hospital regulations adopted by the State Department of Public Health under the Hospital Licensing Act (Ill.Rev.Stat.1963, **257 chap. 111 1/2, pars. 142-157.), to the Standards for Hospital Accreditation of the American Hospital Association, and to the bylaws of the defendant.

[1] As has been seen, the defendant argues in this court that its duty is to be determined by the care customarily offered by hospitals generally in its community. Strictly speaking, the question is not one
of duty, for "** in negligence cases, the duty is always the same, to conform to the legal standard of reasonable conduct in the light of the apparent risk. What the defendant must do, or must not do, is a question of the standard of conduct required to satisfy the duty.' (Prosser on Torst, 3rd ed. at 331.) 'By the great weight of modern American authority a custom either to take or to omit a precaution is generally admissible as bearing on what is proper conduct under the circumstances, but is not conclusive.' (2 Harper and James, The Law of Torts, sec. 17.3, at 977-978.) Custom is relevant in determining the standard of care because it illustrates what is feasible, it suggests a body of knowledge of which the defendant should be aware, and it warns of the possibility of far-reaching consequences if a higher standard is required. (Morris, Custom and Negligence, 42 Colum.L.Rev. 1147 (1942); 2 Wigmore, Evidence, 3rd ed. secs. 459, 461.) But custom should never be conclusive. As Judge Learned Hand said, 'There are, no doubt, cases where courts seem to make the general practice of the calling the standard of proper diligence; we have indeed given some currency to the notion ourselves. ** Indeed in most cases reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative ** that even their universal disregard will not excuse their omission.' The T. J. Hooper (2d cir. 1932), 60 F.2d 737, 740.

[2] In the present case the regulations, standards, and bylaws which the plaintiff introduced into evidence, performed much the same function as did evidence of custom. This evidence aided the jury in deciding what was feasible and what the defendant knew or should have known. It did not conclusively determine the standard of care and the jury was not instructed that it did.

'The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and internes, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.' (Fuld, J., in Bing v. Thunig (1957), 2 N.Y.2d 656, 163 N.Y.S.2d 3, 11, 143 N.E.2d 3, 8.) The Standards for Hospital Accreditation, the state licensing regulations and the defendant's bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient.

[3] We now turn to an application of these considerations to this case. The defendant did not object to the instruction on the issues, which followed Illinois Pattern Jury Instruction 20.01. Nor did it move to withdraw any issues from ** the jury. Under section 68 of the Civil Practice Act, an entire verdict is not to be set aside because one asserted ground of recovery was defective or inadequately proven, if one or more of the grounds is sufficient, unless a motion to withdraw the issue in question ** was made. (Ill.Rev.Stat. 1963, chap. 110, par. 68(4).) Therefore we need not analyze all of the issues submitted to the jury. Two of them were that the defendant had negligently: 5. Failed to have a sufficient number of trained nurses for bedside care of all patients at all times capable of recognizing the progressive gangrenous condition of the plaintiff's right leg, and of bringing the same to the attention of the hospital administration and to the medical staff so that adequate consultation could have been secured and such conditions rectified; ** 7. Failed to require consultation with or examination by members of the hospital surgical staff skilled in such treatment; or to review the treatment rendered to the plaintiff and to require consultants to be called in as needed.'

[4] We believe that the jury verdict is supportable on either of these grounds. On the basis of the evidence before it the jury could reasonably have concluded that the nurses did not test for circulation in the leg as frequently as necessary, that skilled nurses would have promptly recognized the conditions that signalled a dangerous impairment of circulation in the plaintiff's leg, and would have known that the condition would become irreversible in a matter of hours. At that point it became the nurses' duty to inform the attending physician, and if he failed to act, to advise the hospital authorities so that appropriate action might be taken. As to consultation, there is no dispute that the hospital failed to review Dr. Alexander's work or require a consultation; the only issue is whether its failure to do so was negligence.


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On the evidence before it the jury could reasonably have found that it was.

Defendant renews in this court its contention that it was *334 unfairly surprised by an amendment to plaintiff's complaint made at the close of his case. Prior to trial the complaint alleged:

'4. That the defendant corporation then owed to the said plaintiff a duty to use that degree of skill in the care of such patient as would be exercised by institutions of like kind and character in that county; but that in violation of the duties which the said defendant owed to the plaintiff, the said defendant was guilty of one or more of the following negligent and careless acts or omissions which directly and proximately caused injury and loss to the plaintiff:

'O. That the defendant hospital failed to conform to and to observe one or more of the following standards customarily required of and adhered to by accredited hospitals in the area involved at that time * * *.'

[5] At the close of his case plaintiff obtained leave to amend his complaint by changing 'as would be exercised by' in the introductory portion of paragraph 4 to 'required of' and by striking 'customarily required of and' in subparagraph O. The defendant requested a continuance on the ground that it was unfairly surprised because these amendments effected a fundamental shift in theory, in that the plaintiff was now contending that the accreditation rules alone defined the hospital's duty. The trial judge refused the requested continuance. The appellate court found that there was no surprise, and we agree. The 'required of' clause in the introductory paragraph was a legal conclusion. If the 'customarily required of' phrase in subparagraph O was meant to express a legal duty it was also a conclusion; if it was a factual statement, the 'adhered to be accredited hospitals in the area' phrase is no less difficult to prove. But even if there was a change in theory, an examination of the record indicates that defendant was not surprise. The plaintiff had filed a memorandum at the time of the pretrial conference, more than five months before the trial, *335 which stated the theory which the defendant contends is new.

[6] The second major contention advanced by the defendant in this court is **259 that it was prejudicial error to permit the cross-examination of its expert witnesses concerning the views of recognized authorities in their fields, upon the ground that the experts did not purport to base their opinions upon the views of these authorities. In support of this contention he relies upon Ullrich v. Chicago City Ry., 265 Ill. 338, 106 N.E. 828, and City and Bloomington v. Shrock, 110 Ill. 219. Those cases hold that an expert witness can only be interrogated about those texts upon which he expressly bases his opinion. The appellate court held that the cross-examination in this case met that test. We do not consider that determination to ascertain whether every detail on cross-examination of each expert witness fits within the rule announced in those cases, for we are satisfied that the rule is not supported by sound reasons, and should no longer be adhered to.

That rule has been criticized frequently by legal scholars. (6 Wigmore, Evidence, 3d ed. secs. 1690-1692; McCormick, Evidence, sec. 296, p. 620, n. 3.) It was rejected in the Uniform Rules of Evidence (see Rules 63(31) and comment), and in the Model Code of Evidence. (See Rule 529 and comment.) It has been rejected by the United States Supreme Court (Reilly v. Pinkus (1949), 338 U.S. 269, 70 S.Ct. 110, 94 L.Ed. 63), and by other courts as well. (60 A.L.R.2d 77.) It is supported by the considerations that support the hearsay rule, but the inapplicability of those considerations to scientific works has been convincingly demonstrated by Wigmore. 6 Wigmore, Evidence, 3rd ed. secs. 1691-92.

[7] The unsatisfactory quality of expert testimony has been the subject of frequent comment, and it has induced judicial action. (See Opp v. Pryor, 294 Ill. 538, 545, 128 N.E. 580; Kemeny v. Skorch, 22 Ill.App.2d 160, 170, 159 N.E.2d 489; see also Supreme Court Rule 17-2, Ill.Rev.Stat. 1963, chap. 110, par. 101.17-2; Cleary, Handbook of Illinois Evidence, secs. 3.3, p. 41, *336 11.10, pp. 190-191.) An individual becomes an expert by studying and absorbing a body of knowledge. To prevent cross-examination upon the relevant body of knowledge serves only to protect the ignorant or unscrupulous expert witness. In our opinion expert testimony will be a more effective tool in the attainment of justice if cross-examination is permitted as to the views of recognized authorities, expressed in treatises or periodical written for professional colleagues. (Cf. Model Code of Evidence, Rule 529.) The author's competence is established if the judge takes judicial notice of it, or if it is established by a witness expert in the subject.

Another contention of the defendant is that the judgment for $110,000 must be reduced to $100,000, the limit of its liability insurance, because its insurance is its only nontrust fund asset. The
appellate court disposed of this contention on the ground that the defendant's allegations failed to establish that other nontrust funds did not exist. The plaintiff, however, suggests that the doctrine of charitable immunity announced in Parks v. Northwestern University, 218 Ill. 381, 75 N.E. 991, 2 L.R.A. N.S. 556, and modified in Moore v. Moyle, 405 Ill. 555, 92 N.E.2d 81, did not survive the decision of this court in Molitor v. Kaneland Community Unit District, 18 Ill.2d 11, 163 N.E.2d 89, 86 A.L.R.2d 469. It is appropriate that we dispose of that broader contention.

Moore v. Moyle qualified the doctrine of charitable immunity by permitting recovery against nontrust funds of a charitable corporation, specifically an insurance policy. In other respects it adhered to the doctrine of immunity expressed in Parks v. Northwestern University. In the Molitor case the immunity of school districts was sought to be justified upon the theory that it was required in order to protect public funds. In disposing of this contention we said: 'We do not believe that in this present day and age, when public education constitutes one of the biggest businesses in *260 the county, that school immunity can be justified on the protection-of-public-funds theory.

*337 'In the first place, analysis of the theory shows that it is based on the idea that payment of damage claims is a diversion of educational funds to an improper purpose. As many writers have pointed out, the fallacy in this argument is that it assumes the very point which is sought to be proved, i.e., that payment of damage claims is not a proper purpose. 'Logically, the 'No-fund' or 'trust fund' theory is without merit because it is of value only after a determination of what is a proper school expenditure. To predicate immunity upon the theory of a trust fund is merely to argue in a circle, since it assumes an answer to the very question at issue, to wit, what is an educational purpose? Many disagree with the 'no-fund' doctrine to the extent of ruling that the payment of funds for judgments resulting from accidents or injuries in schools is an educational purpose. Nor can it be properly argued that as a result of the abandonment of the common-law rule the district would be completely bankrupt. California, Tennessee, New York, Washington and other states have not been compelled to shut down their schools.' * * * If tax funds can properly be spent to pay premiums on liability insurance, there seems to be no good reason why they cannot be spent to pay the liability itself in the absence of insurance.' (18 Ill.2d at 22-23, 163 N.E.2d at 94-95.) It was pointed out in the dissenting opinion in the Molitor case that the logic of the opinion invalidated the doctrine of charitable immunity. 18 Ill.2d at 38.

[8][9][10] We agree that the doctrine of charitable immunity can no longer stand in the light of Molitor v. Kaneland Community Unit District, 18 Ill.2d 11, 163 N.E.2d 89. In addition to the reasons advanced in the Molitor case, a doctrine which limits the liability of charitable corporations to the amount of liability insurance that they see fit to carry permits them to determine whether or not they will be liable for their torts and the amount of that liability, if any. Whether or not particular assets of a charitable corporation are subject to exemption from execution in order to satisfy a judgment *338 does not determine liability. No such issue arises until liability has been determined. It may be however, that Moore v. Moyle has been relied upon by charitable corporations in deciding whether to carry insurance and, if so, the amount of insurance to be carried. As in the Molitor case, therefore, except as to the plaintiff in the instant case, this aspect of our decision will be given prospective effect only, from the date upon which the opinion in this case becomes final.

[11] One of plaintiff's attorneys in the course of examining Dr. Alexander asked him what had happened to several patients under his care. In each case the patient had died and the only purpose of the question seems to have been to suggest misleading inferences from that fact. One of the patients was over 70 and had died of a heart attack; the others and died of heart conditions or cancer. But explanatory information was supplied on redirect examination, and for that reason we do not consider the initial error in admitting this evidence sufficiently prejudicial to warrant reversal.

[12] The defendant also renews here its contention that the trial court erred in its rulings on instructions. The plaintiff argues that all objections to the instructions were waived because the objectionable ones were not set out at length in the defendant's brief. The appellate court indicated that it accepted this argument, but it also considered the defendant's objections on their merits. No rule of court supports the technical rule for which the plaintiff argues, and we think it is unwarranted.

[13][14][15][16] The defendant objects to the giving of plaintiff's instructions 3A and 6A, which stated certain bylaws and accreditation regulations, on the basis that they **261 singled out evidence. It also
objects to plaintiff's instruction 7B, on the ground that it singled out answers to certain interrogatories. We have examined these instructions and do not believe that prejudicial emphasis was given to any evidence. The defendant also argues that it was error to refuse to instruct *339 the jury that only licensed physicians can practice medicine and that the customary standards of the community establish the duty of the hospital, and to give any instruction which indicated it was the duty of the hospital to supervise the competence of its staff members. The trial court did not err in its ruling upon these matters.

[17] Defendant has renewed in this court some of the other numerous contentions it advanced in the appellate court. All of them were discussed and determined in the exhaustive opinion of the appellate court. (50 Ill.App.2d 253 to 337, 200 N.E.2d 149.) We do not believe it is necessary to discuss them again at length. That court correctly disposed of defendant's arguments concerning improprieties during closing argument. (50 Ill.App.2d at 334–336.

200 N.E.2d 149.) Counsel for both parties indulged in improper argument and we cannot say the improprieties on one side outweighed those on the other.

The judgment of the Appellate Court for the Fourth District is affirmed.

Judgment affirmed.

UNDERWOOD, Justice (specially concurring).

I concur in the decision in so far as it relates to the doctrine of charitable immunity only because I believe this result is compelled by Molitor v. Kaneland Community Unit District, 18 Ill.2d 11, 163 N.E.2d 89.

33 Ill.2d 326, 211 N.E.2d 253, 14 A.L.R.3d 860

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REHABILITATION SERVICES, Plaintiff and Respondent,
v.
Charles F. ANGEL and John A. Fisher, Defendants and Appellants.

No. 13956.

Submitted March 10, 1978.

Appeal was taken from an order of the District Court for the Eighteenth Judicial District, Gallatin County, W. W. Lessley, J., enjoining a physician from continuing to place children for adoption until he obtained a license required of adoption agencies. The Supreme Court, Haswell, C. J., held that: (1) by placing children for adoption, the doctor was acting as an “adoption agency” within the meaning of the statute and was required to have a license, and (2) the court could not judicially create an exception to the licensing statutes for physicians or attorneys so that they could place children for adoption without a license.

Affirmed.

West Headnotes

[1] Amicus Curiae 27

27 Amicus Curiae

27k3 k. Powers, Functions, and Proceedings. Most Cited Cases
Amicus curiae cannot raise separate issues not raised by parties.

[2] Statutes 361

361 Statutes

361VI Construction and Operation

361VI(A) General Rules of Construction

361k187 Meaning of Language

361k188 k. In General. Most Cited Cases
Where intent of Legislature can be determined from plain meaning of words used, courts may not go further and apply other means of interpretation because legislative intent is expressed in language employed.

[3] Infants 211

211 Infants

211II Protection

211k17 k. Societies, Agencies, and Officers in General. Most Cited Cases
(Formerly 211k19.4)
Medical doctor who informed unwed mothers who expressed desire to have their child adopted of married couples he knew that desired to adopt child, and attorney whom doctor recommended to such persons to act as legal counsel to aid them in legal procedures of adoption, were acting as “adoption agency” within plain meaning of statute giving licensed adoption agencies exclusive function of placing children for adoption, and were required to have license. R.C.M.1947, § 10-701 et seq.

[4] Statutes 361

361 Statutes

361VI Construction and Operation

361VI(A) General Rules of Construction

361k226 k. Construction of Statutes
Adopted from Other States or Countries. Most Cited Cases
In determining intent of Legislature in enacting sections of adoption statutes which came from Uniform Adoption Act, it was appropriate to resort to comments of National Conference of Commissioners on Uniform State Laws, who promulgated act. R.C.M.1947, §§ 10-701 et seq., 10-703.

[5] Adoption 17

17 Adoption

17k3 k. Statutory Provisions. Most Cited Cases
Intent of Uniform Adoption Act was to discourage private adoptions. R.C.M.1947, § 10-701 et seq.


92 Constitutional Law

92XX Separation of Powers

92XX(C) Judicial Powers and Functions

92XX(C)2 Encroachment on Legislature

92k2499 Particular Issues and Applications

92k2500 k. In General. Most Cited Cases
(Formerly 92k70.1(7.1), 92k70.1(7))
Supreme Court could not judicially create exception to requirement of adoption statutes that in order to obtain license as adoption agency, agency must be
nonprofit; granting of exception to licensing statutes for physicians or attorneys so that they can place children for adoption without license can only be done by Legislature. R.C.M.1947, §§ 10-701 et seq., 10-703.

Berg, Angel, Andriolo & Morgan, Bozeman, Charles F. Angel, argued, Bozeman, for defendants and appellants.

Richard A. Weber, Jr., argued, Helena, for plaintiff and respondent.

HASWELL, Chief Justice.

Defendants appeal from a declaratory judgment entered by the District Court, Gallatin County. This judgment determined that defendant John A. Fisher's actions, in placing children for adoption, made him an adoption agency within the meaning of section 10-702, R.C.M.1947. By the judgment he was enjoined from continuing to place children for adoption until he obtained a license, required of adoption agencies, from plaintiff.

Defendant John A. Fisher is a medical doctor in Bozeman, Montana, specializing in obstetrics and gynecology. Defendant Charles F. Angel is an attorney in Bozeman, Montana.

Dr. Fisher, as part of his practice, provides medical services for pregnant unwed mothers, both prior to and during the birth of their children. He also renders services to married women, who for any number of reasons, cannot become pregnant but want to have children. In the past, some of the unwed mothers have expressed a desire to have their child adopted after birth. On occasion, when such a desire was expressed, Dr. Fisher would inform these women that he knew of married couples who could not have children of their own and desired to adopt a child. If any of the unwed mothers desired to pursue the matter, Dr. Fisher would talk to a married couple about the possibility of a child being available for adoption. He would advise the couple that they should obtain legal counsel to aid them in the legal procedures of adoption. Dr. Fisher would recommend Charles F. Angel as their legal counsel.

Mr. Angel would then represent the adoptive parents in adoption proceedings in the courts. At all times, Mr. Angel knew that Dr. Fisher was not licensed as an adoption agency.

On April 20, 1977, plaintiff filed this declaratory judgment action and petition for injunctive relief against defendants. Plaintiff sought a determination that defendants' actions in placing children for adoption were such that they could not carry on the same without a valid license issued by plaintiff. They also requested that defendants be enjoined from similar future actions in the absence of a proper license.

A hearing was held in this case on June 3, 1977. On July 5, 1977, the District Court entered findings of fact and conclusions of law determining that Dr. Fisher in assisting unwed mothers in the placement of their children after birth, with prospective adoptive parents was acting as an adoption agency for which he needed a license from plaintiff. On July 11, 1977, the District Court entered a judgment in accordance with its findings of fact and conclusions of law and enjoined defendants from placing children for adoption until a license was obtained. Defendants made a motion to have additional findings and conclusions entered and raising exceptions to the court's conclusions of law. Following denial of this motion, defendants appeal.

The sole issue raised by the parties to this appeal is: whether sections 10-701 et seq., R.C.M.1947, prohibit a medical doctor from assisting an unwed pregnant mother in the placement of her child after birth with prospective adoptive parents when the doctor is not licensed as an adoption agency under these statutes.

[1] An amicus curiae brief was filed by Suzanne Hoell, of the Coalition of Adoptive Parents, raising additional issues not raised by the parties. We decline to discuss these as amicus curiae cannot raise separate issues not raised by the parties. State ex rel. Kvaalen v. Graybill (1972), 159 Mont. 190, 496 P.2d 1127.

*396[2][3] The issue presented in this appeal is one of statutory interpretation. The approach we take in interpreting a statute was recently stated in Montana Department of Revenue v. American Smelting and Refining Company (1977), Mont., 567 P.2d 901, 34 St.Rep. 597. Where the intent of the legislature can be determined from the plain meaning of the words used, the courts may not go further and apply other means of interpretation because the legislative intent
is expressed in the language employed. In this case, the legislative intent is obvious from the plain meaning of the words used in sections 10-701, et seq., R.C.M.1947, viz. **1225 to give licensed adoption agencies the exclusive function of placing children for adoption. If a medical doctor is going to place children for adoption, he is acting as an adoption agency and must have a license.

Our interpretation is not unique. Other jurisdictions with similar statutes, varying somewhat in wording, have reached the same result. For example, see: Goodman v. District of Columbia (1947), D.C.Mun.App., 50 A.2d 812; Dobkin v. District of Columbia (1963), D.C.App., 194 A.2d 657; In re McDonald's Adoption (1954), 43 Cal.2d 447, 274 P.2d 860; In re Adoption of Anonymous (1965), 46 Misc.2d 928, 261 N.Y.S.2d 439.

However, defendants argue that the “plain meaning” of sections 10-701, et seq., is not clear. They base their argument on their interpretation of Title 61, Chapter 2, Montana's Adoption Statute. Defendants' claim that the legislature, in drafting the adoption statute, recognized occasional private adoptions and made a provision for them. According to defendants, these provisions are the sections on investigations of prospective adoptive homes and the authorization of trial periods in the adoptive home before the final decree of adoption is entered. Sections 61-209 and 61-211, R.C.M.1947. They argue that if all the placements of children for adoption had to come through adoption agencies there would be no need for an investigation in the adoptive home or for use of a trial period in the home before the final decree is entered. We disagree.

[4] Since these sections come from the Uniform Adoption Act, *397 we believe that resort to the comments of the National Conference of Commissioners on Uniform State Laws, who promulgated the act, is appropriate to determine the intent of the act. The comments state:

“Several sections attempt to deal with so-called black market operations in children. While the Act does not prohibit private placement of children, it attempts to discourage black market adoptions and private placements.” 9 U.L.A. Uniform Adoption Act, p. 9.

[5] Thus, it can be seen that the intent of the Uniform Adoption Act was to discourage private adoptions.

We believe that this intent combined with the legislative intent in language employed in Montana's sections 10-701, et seq., shows that the legislature intended to make the placement of children for adoption the exclusive function of licensed adoption agencies.

[6] Defendants' final argument is that because he is a physician he cannot obtain a license as an adoption agency. Section 10-703, R.C.M.1947, establishes the requirements for a license. One of the requirements is that the agency must be nonprofit. Defendants claim that it is because of this requirement that they cannot obtain a license. They argue that an exemption then should be made from the licensing requirement for them. To grant defendants the exemption they request would be to contravene the intent of the legislature in establishing the licensing statute in our view. We cannot judicially create an exception to a statutory requirement that the legislature chose not to include. The granting of an exception to the licensing statutes for physicians or attorneys so that they can place children for adoption without a license can only be done by the legislature.

The judgment of the District Court is affirmed.

DALY, HARRISON and SHEA, JJ., and ALFRED B. COATE, District Judge, concur.

Mont., 1978.

Montana Dept. of Social and Rehabilitation Services v. Angel
176 Mont. 293, 577 P.2d 1223

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Supreme Court of Montana.
Lee N. THOMPSON, Darin Sharp and Scott Bailey, Petitioners and Respondents,
v.
STATE of Montana, Respondent and Appellant,
and Liberty Northwest Insurance Corporation and Montana State Fund, Intervenors and Appellants.
No. DA 06-0365.

Argued Nov. 15, 2006.

Background: State, workers compensation carrier, and Montana State Fund sought review of declaratory judgment of the Workers' Compensation Court (WCC), granting claimants' motion for summary judgment and finding that claimant disclosure statutes violated claimants' state constitutional right to privacy and due process rights.

Holdings: The Supreme Court, James C. Nelson, J., held that:
(1) WCC did not have jurisdiction to issue declaratory judgment in absence of particular dispute over benefits;
(2) admission by defendants that WCC had jurisdiction could not confer jurisdiction on the WCC;
(3) WCC was not empowered by Uniform Declaratory Judgments Act (UDJA) to enter declaratory judgment because it was not a "court of record"; and
(4) WCC could not award claimants attorney fees pursuant to UDJA.

Reversed.

W. William Leaphart, J., dissented and filed an opinion.

West Headnotes

[1] Statutes 361 176

361 Statutes
361VI Construction and Operation
361VI(A) General Rules of Construction
361k176 k. Judicial Authority and Duty.

Most Cited Cases

Interpretation and construction of a statute is a matter of law.


106 Courts
106I Nature, Extent, and Exercise of Jurisdiction in General
106k39 k. Determination of Questions of Jurisdiction in General. Most Cited Cases
A court's determination as to its jurisdiction is a conclusion of law.

[3] Workers' Compensation 413 1939.1

413 Workers' Compensation
413XVI Proceedings to Secure Compensation
413XVI(T) Review by Court
413XVI(T)12A Questions of Law or Fact, Findings, and Verdict
413k1939 Review of Decision of Department, Commission, Board, Officer, or Arbitrator
413k1939.1 k. In General; Questions of Law or Fact. Most Cited Cases
The Supreme Court reviews a Workers' Compensation Court's (WCC's) conclusions of law to determine whether the court's conclusions are correct.

[4] Workers' Compensation 413 1086

413 Workers' Compensation
413XII Administrative Officers and Boards
413k1085 Jurisdiction
413k1086 k. In General. Most Cited Cases
The Workers' Compensation Court (WCC) did not have jurisdiction to issue declaratory judgment holding claimant disclosure statutory provisions unconstitutional, in action that did not involve a particular dispute over benefits and did not concern the applicability of the statutes to that dispute. MCA 2-4-501, 39-71-604(3), 39-71-2905(1), 50-16-527(5).

[5] Workers' Compensation 413 1079

413 Workers' Compensation
413XII Administrative Officers and Boards
413k1077 Status and Character
413k1079 k. Judicial or Administrative. Most Cited Cases
Workers' Compensation 413 $\Rightarrow$ 1086

413 Workers' Compensation
413XII Administrative Officers and Boards
413k1085 Jurisdiction
413k1086 k. In General. Most Cited Cases
The Workers' Compensation Court (WCC) is a court of limited jurisdiction; in particular, the WCC is an administrative tribunal governed by the Montana Administrative Procedure Act (MAPA) and allocated to the Department of Labor and Industry for administrative purposes. MCA 2-4-101 to 2-4-711, 2-15-1707(1).

[6] Courts 106 $\Rightarrow$ 159

106 Courts
106IV Courts of Limited or Inferior Jurisdiction
106k159 k. Nature and Scope of Limitations in General. Most Cited Cases
Courts of limited jurisdiction have only such power as is expressly conferred by statute.

[7] Workers' Compensation 413 $\Rightarrow$ 1184

413 Workers' Compensation
413XVI Proceedings to Secure Compensation
413XVI(A) In General
413k1176 Jurisdiction of Boards and Commissions
413k1184 k. Scope and Extent. Most Cited Cases
The Workers' Compensation Court (WCC) is authorized by statute to issue declaratory rulings only in the context of a dispute concerning benefits under the Workers' Compensation Act and only as to the applicability of any statutory provision, rule, or order of the agency to that dispute. MCA 2-4-501, 39-71-604(3), 39-71-2905(1), 50-16-527(5).

[8] Workers' Compensation 413 $\Rightarrow$ 1089

413 Workers' Compensation
413XII Administrative Officers and Boards
413k1085 Jurisdiction
413k1089 k. Consent of Parties, Waiver, and Estoppel. Most Cited Cases
Admission by State and other defendants that Workers' Compensation Court (WCC) had jurisdiction to issue declaratory judgment as to constitutionality of claimant disclosure statutory provisions could not confer jurisdiction on the WCC, where case did not involve a dispute over benefits. MCA 39-71-604(3), 50-16-527(5).

[9] Courts 106 $\Rightarrow$ 4

106 Courts
106I Nature, Extent, and Exercise of Jurisdiction in General
106k3 Jurisdiction of Cause of Action
106k4 k. In General. Most Cited Cases
Courts 106 $\Rightarrow$ 37(1)

106 Courts
106I Nature, Extent, and Exercise of Jurisdiction in General
106k37 Waiver of Objections
106k37(1) k. In General. Most Cited Cases
Jurisdiction involves the fundamental power and authority of a court to determine and hear an issue; accordingly, subject-matter jurisdiction can never be forfeited or waived.

[10] Courts 106 $\Rightarrow$ 24

106 Courts
106I Nature, Extent, and Exercise of Jurisdiction in General
106k22 Consent of Parties as to Jurisdiction
106k24 k. Of Cause of Action or Subject-Matter. Most Cited Cases
Subject-matter jurisdiction cannot be conferred by the consent of a party.


118A Declaratory Judgment
118AHII Proceedings
118AHII(B) Jurisdiction and Venue
118Ak273 k. Jurisdiction of Particular State Courts. Most Cited Cases
Workers' Compensation 413 $\Rightarrow$ 1079

413 Workers' Compensation
413XII Administrative Officers and Boards
413k1077 Status and Character
413k1079 k. Judicial or Administrative. Most Cited Cases
Workers' Compensation 413 $\Rightarrow$ 1090

413 Workers' Compensation

413XII Administrative Officers and Boards

413k1090 k. Powers and Duties in General.

Most Cited Cases

Under statute in effect when claimants filed declaratory judgment action in the Workers' Compensation Court (WCC), the WCC was not a “court of record,” and thus WCC was not empowered by the Uniform Declaratory Judgments Act (UDJA) to enter declaratory judgment holding claimant disclosure statutory provisions unconstitutional, in action that did not involve a particular dispute over benefits; only courts listed by the statute were “courts of record.” MCA 3-1-102, 27-8-201, 39-71-604(3), 50-16-527(5).

[12] Costs 102 C==197

102 Costs

102IX Taxation

102k197 k. Jurisdiction and Authority. Most Cited Cases

Workers' Compensation 413 C==1981

413 Workers' Compensation

413XVI Proceedings to Secure Compensation

413XVI(U) Costs, Expenses, and Attorney Fees

413k1980 Attorney Fees

413k1981 k. In General. Most Cited Cases

Workers' Compensation Court (WCC) could not award claimants attorney fees pursuant to the Uniform Declaratory Judgments Act (UDJA), in claimants' action seeking declaration that certain claimant disclosure procedures were unconstitutional, given a finding that the WCC was not a “court of record” and, thus, was not authorized by UDJA to enter declaratory judgment. MCA 27-8-311, 39-71-604(3), 50-16-527(5).

[13] Costs 102 C==194.16

102 Costs

102VIII Attorney Fees

102k194.16 k. American Rule; Necessity of Contractual or Statutory Authorization or Grounds in Equity. Most Cited Cases

The general rule is that absent a statutory or contractual provision, attorney fees are not recoverable.

**869 For Appellant: Hon. Mike McGrath, Montana Attorney General, Anthony Johnstone (argued), Assistant Attorney General, Helena, Montana.

For Intervenors-Appellants: Kevin Braun (argued), Special Assistant Attorney General, Montana State Fund, Helena, Montana, Larry W. Jones (argued), Law Offices of Larry W. Jones, Missoula, Montana.

For Respondents: Norman L. Newhall (argued), Linnell, Newhall, Martin & Schulte, P.C., Great Falls, MT.

Justice JAMES C. NELSON delivered the Opinion of the Court.

*512 ¶ 1 Lee Thompson, Darin Sharp, and Scott Bailey (collectively, “the Workers”) each filed claims in the Workers' Compensation Court (“WCC”) for workers' compensation benefits. In a separate action, the Workers jointly filed a Petition for Declaratory Judgment in the WCC, naming the State of Montana (“State”) as the sole respondent. They sought a declaration stating that the claimant disclosure procedures, specifically the claimant disclosure waiver provisions set forth in *513 §§ 39-71-604(3) and 50-16-527(5), MCA (2003)FN1 violated their state constitutional right to privacy and deprived them of property without due process of law. The WCC allowed Liberty Northwest Insurance Corporation (“Liberty”) and Montana State Fund (“MSF”; collectively, “Intervenors”) to intervene in the action. The WCC then granted summary judgment in favor of the Workers and held that §§ 39-71-604(3) and 50-16-527(5), MCA, were unconstitutional. The WCC also awarded attorney's fees and costs against the State. Subsequently, the WCC denied Liberty's Motion for Reconsideration. The State and Intervenors (collectively, “Appellants”) appeal. We reverse.

FN1 We note that in 2003, the Legislature amended §§ 39-71-604(3) and 50-16-527(5), MCA. The 2003 amendments made two significant changes to both §§ 39-71-604(3) and 50-16-527(5), MCA. First, the Legislature provided explicitly for the disclosure and communication of health care information. Second, the Legislature provided for such disclosure without prior notice to the injured employee. Neither §§
¶ 2 Appellants raise multiple and overlapping issues on appeal, which we restate as follows:

1. Did the WCC err by concluding that it had jurisdiction to enter a declaratory judgment in the particular context of this case?

2. Did the WCC err when it awarded attorney's fees and costs against the State?

3. Did the WCC err by ruling that the claimant disclosure procedures of §§ 39-71-604(3) and 50-16-527(5), MCA, violate a workers' compensation claimant's constitutional right to privacy under Article II, Section 10 of the Montana Constitution?

4. Did the WCC err by ruling that the claimant disclosure procedures of §§ 39-71-604(3) and 50-16-527(5), MCA, deprive a workers' compensation claimant of property without due process of law under Article II, Section 17 of the Montana Constitution?

¶ 3 Because the first two issues are dispositive of this appeal, we do not address Issue 3 or Issue 4. On appeal, MSF confines its arguments solely to Issues 3 and 4. Thus, we will not address MSF's arguments. Instead, we will address the arguments presented by the State and Liberty pertaining to Issues 1 and 2.

FACTUAL AND PROCEDURAL BACKGROUND

¶ 4 On June 30, 2004, the Workers filed a Petition for Declaratory Judgment ("Petition") in the WCC. The State was the only respondent named in the Petition. The Workers sought a declaratory judgment stating that §§ 39-71-604(3) and 50-16-527(5), MCA, are unconstitutional under Article II, Section 10 of the Montana Constitution. Article II, Section 10 of the Montana Constitution provides that "[t]he right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest."

¶ 5 Section 39-71-604(3), MCA, a provision of the Workers' Compensation Act, states that "[a] signed claim for workers' compensation or occupational disease benefits or a signed release authorizes a workers' compensation insurer ... to communicate with a physician or other health care provider about relevant health care information" and to receive such relevant information "without prior notice to the injured employee." The Uniform Health Care Information Act, codified as §§ 50-16-501 to-553, MCA, provides that a patient may authorize a health care provider to disclose the patient's health care information if the authorization identifies the nature of the information to be disclosed and identifies the person to whom the information is to be disclosed. Section 50-16-526, MCA, Section 50-16-527, MCA, in turn, explicitly provides an exception to the general rules set forth in § 50-16-526, MCA. Under § 50-16-527(5), MCA, a signed claim for workers' compensation benefits or a signed release authorizes a workers' compensation insurer to communicate with a physician or other health care provider about relevant health care information and receive such information without prior notice to the injured employee. The language of § 50-16-527(5), MCA, is, for all intents and purposes, identical to the language of § 39-71-604(3), MCA.

¶ 6 Essentially, the Workers argued that the claimant disclosure procedures set forth in §§ 39-71-604(3) and 50-16-527(5), MCA, violated their state constitutional right to privacy because there was no compelling state interest which supported the right of private insurers to engage in private communications with health care providers for an injured employee. The Workers also asked the WCC to award reasonable attorney's fees and costs against the State.

¶ 7 On July 21, 2004, pursuant to Admin. R.M. 24.5.309 and M.R. Civ. P. 24(a), Liberty moved to intervene in this action. According to Liberty, it is the "largest private workers' compensation carrier in the State of Montana." The WCC granted Liberty's motion to intervene on July 26, 2004. MSF subsequently filed a motion to intervene, also pursuant to Admin. R.M. 24.5.309 and M.R. Civ. P. 24(a), on August 23, 2004. MSF argued that a ruling on the constitutionality of § 39-71-604, MCA, would affect all workers' compensation insurance carriers in Montana, including MSF. On August 26, 2004, the WCC granted MSF's motion to intervene.

¶ 8 The Workers moved for summary judgment on October 15, 2004, asserting that no genuine issues of
9 On January 25, 2005, before the WCC ruled on the motion for summary judgment, the Workers filed a motion to amend their Petition. In addition to their original request that §§ 39-71-604(3) and 50-16-527(5), MCA, be declared unconstitutional under Article II, Section 10 of the Montana Constitution, the Workers also sought a declaration stating that §§ 39-71-604(3) and 50-16-527(5), MCA, are unconstitutional under the Fourth, Ninth, and Fourteenth Amendments to the United States Constitution.

10 On May 6, 2005, the Workers filed a second motion for summary judgment, again asserting that no genuine issues of material fact existed. The Workers renewed their request for summary judgment on the right to privacy issue and also moved for summary judgment on the ground that §§ 39-71-604(3) and 50-16-527(5), MCA, violated their “rights to due process of law under Article II, § 17 of the Montana Constitution and under the Fifth and Fourteenth Amendments to the United States Constitution.”

11 On October 18, 2005, the WCC granted summary judgment in favor of the Workers. The WCC declared that §§ 39-71-604(3) and 50-16-527(5), MCA, violated Article II, Sections 10 and 17 of the Montana Constitution. Further, the WCC noted that it need not address the constitutional challenges raised by the Workers pursuant to the Fifth and Fourteenth Amendments to the United States Constitution. Lastly, the WCC stated that the Workers' request for attorney's fees and costs was “well taken” and ordered the Workers to submit an itemization of attorney's fees and an application for taxation of costs. On October 19, 2005, the WCC issued an order amending its Order Granting Motions for Summary Judgment to correct a typographical error.

12 On November 4, 2005, Liberty filed a lengthy Motion to Reconsider. Three days later, MSF filed a Request for Clarification, inquiring as to the constitutionality of §§ 39-71-604(3) and 50-16-527(4), MCA, which also set forth claimant disclosure procedures. In a response dated November 16, 2005, the State noted that it did not oppose Liberty's Motion to Reconsider. Additionally, the State objected to the WCC's award of attorney's fees and costs and also questioned the WCC's jurisdiction to make such an award.

13 On April 28, 2006, the WCC denied Liberty's Motion to Reconsider and rejected the State's challenge to the WCC's jurisdiction to award attorney's fees and costs. In the course of its analysis, the WCC also addressed its jurisdiction to issue a declaratory judgment in this case. The WCC did not respond to MSF's Request for Clarification. Appellants appeal from the October 18, 2005 Order Granting Motions for Summary Judgment, the October 19, 2005 Order Amending Order Granting Motions for Summary Judgment, and the April 28, 2006 Order Denying Intervenors' Motion for Reconsideration.

STANDARD OF REVIEW


DISCUSSION
¶ 15 Did the WCC err by concluding that it had jurisdiction to enter a declaratory judgment in the particular context of this case?

¶ 16 The State contends that the WCC erred by concluding that it had jurisdiction to enter a declaratory judgment concerning the constitutionality of §§ 39-71-604(3) and 50-16-527(5), MCA, in the context of this case. This question first arose after the WCC had entered its order granting summary judgment in favor of the Workers. In its order denying Liberty's Motion to Reconsider, the WCC determined that it had jurisdiction to enter a declaratory judgment in this case for the following reasons.

¶ 17 The WCC noted that the Uniform Declaratory Judgments Act (“UDJA”), codified at §§ 27-8-101 to-313, MCA, provides that “[c]ourts of record within their respective jurisdictions shall have power to declare rights, status, and other legal relations whether or not further relief is or could be claimed.” Section 27-8-201, MCA. The WCC then determined that the failure of the Legislature to include the WCC in the list of the courts of record enumerated in § 3-1-102, MCA, does not mean that the WCC is not a court of record. According to the WCC, reasoning by analogy, the failure of the Legislature to include it in the list of the courts of justice of this state, set forth in § 3-1-101, MCA, would also mean that the WCC is not a court of justice. It maintained that this reasoning produced “an undoubtedly absurd result.”

¶ 18 The WCC further reasoned that Appellants had asked it to insert language into § 3-1-102, MCA, so that it would effectively state that “the municipal courts and no others are courts of record.” The WCC noted that “[a]lthough § 3-1-102, MCA, enumerates several courts as courts of record, it contains no limiting language to indicate that only those courts mentioned qualify as courts of record in this State.” The WCC maintained, therefore, that it was not free to construe § 3-1-102, MCA, in such a manner so as to exclude the WCC from the list of the courts of record.

FN2. The WCC appears to have been quoting the pre-2005 version of § 3-1-102, MCA. In 2005, the Legislature added “justices' courts of record” to the list of courts of record. Thus, § 3-1-102, MCA, now provides: “The court of impeachment, the supreme court, the district courts, the municipal courts, and the justices' courts of record are courts of record.”

¶ 19 Lastly, the WCC observed that it had the same contempt powers as the district courts and that appeals from the WCC proceed directly to the Montana Supreme Court. On these grounds, the WCC concluded that it must be a court of record as contemplated by the UDJA.

¶ 20 As an alternative theory, the WCC reasoned that if it did not have jurisdiction to issue declaratory judgments concerning the constitutionality of workers' compensation statutes, “it begs the question not only as to which court would have jurisdiction to do so, but what would be the practical effect for a petitioner whose prayer for declaratory judgment is an argument in the alternative to other workers' compensation issues which belong in this Court.” The WCC speculated that, more importantly, it was in the best position to make determinations as to the constitutionality of workers' compensation statutes. Therefore, for all of these reasons, the WCC concluded that it had jurisdiction to issue a declaratory judgment in this case.

¶ 21 The State argues on appeal that the WCC's conclusion is erroneous. First, the State contends that the WCC is a court of limited jurisdiction and that it may only hear a petition brought by a claimant or an insurer concerning workers' compensation benefits. In the State's view, the WCC's jurisdiction may extend to other benefit-related issues, but only so long as the underlying dispute is related to benefits payable to a claimant. The State cites Alaska Pac. Assur. Co. v. L.H.C., Inc., 191 Mont. 120, 124, 622 P.2d 224, 226 (1981), for the proposition that the WCC does not have jurisdiction when a petition filed by a claimant does not in any way indicate that the claimant was then being deprived of compensation benefits. The State asserts that the Workers' Petition demanded neither benefits nor a declaratory judgment concerning their entitlement to benefits. Therefore, the State argues that the Workers' Petition was not properly before the WCC and, accordingly, that the WCC lacked jurisdiction.

FN3. We note that Liberty also challenges the WCC's conclusion concerning its jurisdiction to issue a declaratory judgment in this case. However, Liberty's arguments
are encompassed by the State's arguments on this issue, and the State makes a number of arguments not made by Liberty. We therefore set forth the arguments as they are framed by the State.

¶ 22 Second, the State asserts that the only source of authority within the Montana Administrative Procedure Act ("MAPA"; §§ 2-4-101 to -711, MCA) by which the WCC could issue declaratory judgments is § 2-4-501, MCA, which provides that "[e]ach agency shall provide by rule for the filing and prompt disposition of petitions for declaratory rulings as to the applicability of any statutory provision or of any rule or order of the agency" (emphasis added). In addition, the State notes that the WCC can issue declaratory rulings pursuant to Admin. R.M. 24.5.351(1) "[w]here the court has jurisdiction" to do so. Therefore, according to the State, the WCC's authority to issue declaratory judgments or rulings is limited to the applicability of statutes and rules concerning disputes over workers' compensation benefits.

¶ 23 Lastly, the State argues that the UDJA does not confer jurisdiction on the WCC to issue declaratory judgments. The State maintains that courts of record are limited by statute to those listed in § 3-1-102, MCA. Section 3-1-102, MCA, provides that "[t]he courts of impeachment, the supreme court, the district courts, the municipal courts, and the justices' courts of record are courts of record." The State argues that because the WCC is not included in this list, the WCC is not a court of record. Therefore, the State maintains that the UDJA does not confer jurisdiction upon the WCC to issue declaratory judgments outside the realm of a dispute concerning workers' compensation benefits.

Our holdings are encompassed by the State's arguments on this issue, and the State makes a number of arguments not made by Liberty. We therefore set forth the arguments as they are framed by the State.

¶ 24 We agree with the State that the WCC did not have jurisdiction to issue a declaratory judgment holding §§ 39-71-604(3) and 50-16-527(5), MCA, unconstitutional in the particular context of this case. Unlike the general jurisdiction granted to district courts over "all cases in law and in equity," § 3-5-302(1), MCA, the WCC is a court of limited jurisdiction, Obergser v. Federated Mut. Ins. Co., 2005 MT 329, ¶ 11, 330 Mont. 1, ¶ 11, 126 P.3d 459, ¶ 11. In particular, the WCC is an administrative tribunal governed by MAPA and allocated to the Department of Labor and Industry for administrative purposes. See Kloepfer v. Lumbermens Mut. Cas.

Co., 272 Mont. 78, 81, 899 P.2d 1081, 1083 (1995) ("The statutes governing workers' compensation claims direct the Workers' Compensation Court to be bound by "the Montana Administrative Procedure Act."” (quoting § 39-71-2903, MCA); Wheeler v. Carlson Transport, 217 Mont. 254, 263, 704 P.2d 49, 55 (1985) (stating that the WCC is an administrative tribunal); Hert v. J.J. Newberry Co., 179 Mont. 160, 161, 587 P.2d 11, 12 (1978) ("[H]earings before the Workers' Compensation Court are considered to be administrative proceedings."); § 2-15-1707(1), MCA ("The office [of workers' compensation judge] is allocated to the department of labor and industry for administrative purposes only as prescribed in 2-15-121."). Courts of limited jurisdiction have only such power as is expressly conferred by statute. See Jenkins v. Carroll, 42 Mont. 302, 312, 112 P. 1064, 1069 (1910).

FN4. The WCC apparently proceeded on the premise that it had jurisdiction to issue a declaratory ruling in this case unless that jurisdiction was withdrawn by a provision of law. This premise was incorrect. Because courts of limited jurisdiction have only such power as is expressly conferred by statute, the correct starting premise is that the WCC- or any other court of limited jurisdiction, for that matter does not have the jurisdiction in question unless that jurisdiction is conferred by a specific provision of law.

¶ 25 The pertinent statutes here are §§ 2-4-501 and 39-71-2905(1), MCA. The latter provides that the WCC has jurisdiction over "dispute[s] concerning any benefits under [the Workers' Compensation Act, Title 39, Chapter 71, MCA].” Section 39-71-2905(1), MCA; see also Noonkester, ¶¶ 20, 23; Liberty Northwest Insurance Corp. v. State Compensation Insurance Fund, 1998 MT 169, ¶ 11, 289 Mont. 475, ¶ 11, 962 P.2d 1167, ¶ 11, Section 2-4-501, MCA, in turn, authorizes declaratory rulings “as to the applicability of any statutory provision or of any rule or order of the agency.” Taken together, these statutes authorize the WCC to issue declaratory rulings only in the context of a dispute concerning benefits under the Workers' Compensation Act and only as to the applicability of any statutory provision, rule, or order of the agency to that dispute.

¶ 26 Here, the Workers' Petition did not demand benefits or a declaratory judgment concerning the
applicability of workers' compensation statutes to a
particular dispute **874 over benefits. Indeed, the
Workers concede in their brief that “[h]ere, no benefits are at issue.” Therefore, we hold that the
WCC did not have jurisdiction to issue a declaratory
judgment holding §§ 39-71-604(3) and 50-16-527(5),
MCA, unconstitutional in the context of this case.

[8] ¶ 27 The Workers seek to avoid this holding based on
the following four theories. First, the
Workers argue that the WCC had jurisdiction to issue a declaratory judgment concerning
the constitutionality of §§ 39-71-604(3) and 50-16-
527(5), MCA, because Appellants admitted in their
responses to the Petition that the issues raised therein were “appropriate for a declaratory judgment by [the
WCC].” The Workers cite Audit Services v. Frontier-
West, Inc., 252 Mont. 142, 148-49, 827 P.2d 1242,
1247 (1992), in which this Court stated that “[i]t is
well settled that the parties are bound by and
estopped from controverting admissions in their
pleadings.” Relying on Audit Services, the Workers
contend that Appellants are estopped from
challenging the jurisdiction of the WCC to issue a
declaratory judgment concerning the constitutionality of §§ 39-71-604(3) and 50-16-527(5), MCA.

[9][10] ¶ 28 We reject this argument outright.
“Jurisdiction involves the fundamental power and
authority of a court to determine and hear an issue.”
Stanley, ¶ 30 (citing State v. Diesen, 1998 MT 163, ¶
5, 290 Mont. 55, ¶ 5, 964 P.2d 712, ¶ 5). Accordingly, subject-matter jurisdiction can never be
forfeited or waived. Stanley, ¶ 32 (citing Arbaugh v.
Y & H Corp., 546 U.S. 500, 513, 126 S.Ct. 1235,
1244, 163 L.Ed.2d 1097 (2006) ). Additionally,
subject-matter jurisdiction cannot be conferred by the
consent of a party. In re Marriage of Miller, 259
Therefore, “[t]he issue of subject matter jurisdiction
may be raised by a party, or by the court itself, at
any stage of a judicial proceeding.” Noonkester, ¶ 29
(citing State v. Tweedy, 277 Mont. 313, 315, 922
P.2d 1134, 1135 (1996)). Consequently, Appellants' admissions in their responses to the Workers' Petition cannot confer jurisdiction that otherwise does not
exist.

FN5. Counsel for the Workers conceded this
point during oral argument.

¶ 29 Second, the Workers contend that the WCC's
jurisdiction is not confined to disputes concerning
benefits. As support for this proposition, the Workers
cite Wunderlich v. Lumbermens Mut. Cas. Co., 270
518, 625 P.2d 539, 542 (1981). The Workers also
rely on Gould v. County Market Super Valu Stores,
233 Mont. 494, 497, 766 P.2d 213, 215 (1988), in
which this Court stated that the WCC’s jurisdiction is
“limited to workers’ compensation matters, and its
procedures are less formal,” but that its decisions are
“something more than administrative agency
decisions.” Along these same lines, the Workers
assert that the authority of the WCC is broader than
that exercised by an agency because decisions of the
WCC are appealed directly to the Montana Supreme
Court. Finally, the Workers claim that under § 39-71-
203, MCA, the WCC is vested with the “power,
authority, and jurisdiction necessary to the exercise
of its power to conduct proceedings and hearings and
make determinations concerning disputes” under
Title 39, Chapter 71, MCA. Therefore, according to
the Workers, the jurisdiction of the WCC extends
beyond disputes concerning benefits and is not
restricted by the fact that its proceedings are
conducted under MAPA.

¶ 30 It is true that the history of the WCC and the
statute providing for exclusive jurisdiction in that
court “to make determinations concerning disputes under [the Workers Compensation Act],” § 39-71-
2905(1), MCA, indicate that “the jurisdiction of the
court goes beyond that minimum whenever the
dispute is related to benefits payable to a claimant,”
Hunt, 191 Mont. at 519, 625 P.2d at 542. This does
not mean, however, that the WCC may issue
declaratory rulings outside the context of a dispute
concerning benefits, and none of the cases cited by
the Workers support their contention that the WCC’s
jurisdiction is not confined to disputes concerning
benefits. See **875Wunderlich, 270 Mont. at 409,
892 P.2d at 567 (analyzing the WCC’s ruling made in
the context of a dispute over benefits); Miller, 264
Mont. at 361-62, 871 P.2d 1302 at 1307 (same),
Gould, 233 Mont. at 500-01, 766 P.2d at 217 (same),
and Hunt, 191 Mont. at 518, 625 P.2d at 542 (same).

[11] ¶ 31 Third, the Workers argue that nothing in the
UDJA expressly limits the power to enter declaratory
judgments under § 27-8-201, MCA, to only
those courts of record enumerated in § 3-1-102.
The court, by \( \text{§} \) \( \text{1-2-101}, \) \( \text{MCA} \). provides that courts of record within their respective jurisdictions shall have power to declare rights, status, and other legal relations whether or not further relief is or could be claimed (emphasis added.) MAPA provides that the WCC shall maintain a stenographic record of oral proceedings when demanded by a party, \( \text{§} \) \( \text{2-4-614}, \) \( \text{MCA} \); accordingly, the Workers suggest that the WCC is “technically” a court of record as contemplated by the UDJA. Therefore, according to the Workers, the WCC had jurisdiction in this case to issue a declaratory judgment stating that \( \text{§§} \) \( \text{39-71-604(3)} \) and \( \text{50-16-527(5)}, \) \( \text{MCA} \), are unconstitutional.

¶ 32 The State characterizes the Workers' attempt to categorize the WCC as a court of record as “bizarre.” Irrespective of this characterization, we agree with the State that the Workers' position is without merit. For one thing, \( \text{§} \) \( \text{3-1-102}, \) \( \text{MCA} \), sets forth the courts of record in this state. They are as follows: “[t]he court of impeachment, the supreme court, the district courts, the municipal courts, and the justices' courts of record are courts of record.” Section 3-1-102, \( \text{MCA} \). The WCC does not appear in this list, and neither we nor the WCC may read the WCC into the list at the request of the Workers. See\( \text{§} \) \( \text{1-2-101}, \) \( \text{MCA} \) (“In the construction of a statute, the office of the judge is simply to ascertain and declare what is in terms or in substance contained therein, not to insert what has been omitted.”).\( \text{FN6} \)

\[ \text{FN6} \] In this regard, we note that the WCC reasoned that Appellants were asking it to insert language into \( \text{§} \) \( \text{3-1-102}, \) \( \text{MCA} \), so that the statute would effectively read: “The court of impeachment, the supreme court, the district courts, the municipal courts, and the justices' courts of record, and no others, are courts of record” (underscore for new language). Yet it was the WCC that inserted language into \( \text{§} \) \( \text{3-1-102}, \) \( \text{MCA} \), by effectively adding “the workers' compensation court” to the list contained therein. When the Legislature has provided an exclusive listing in a statute, there is no need to insert limiting but extraneous language (i.e., “and no others”).

Furthermore, the Legislature clearly is capable of expanding the list of the courts of record as it did in 2005 when it added the justices' courts of record (see ¶ 18 n. 2). Indeed, during the 2007 Session, the Legislature passed, and the Governor signed, Senate Bill No. 523, which amends \( \text{§} \) \( \text{3-1-102}, \) \( \text{MCA} \), to read: “The court of impeachment, the supreme court, the district courts, the workers' compensation court, the municipal courts, and the justices' courts of record are courts of record” (underscore for new language). The fact that the WCC was not heretofore included in the list of courts of record contained in \( \text{§} \) \( \text{3-1-102}, \) \( \text{MCA} \), but will be included in that list beginning October 1, 2007 (the effective date of the amendment), only bolsters our conclusion that during the time period at issue here, the WCC was not a court of record.

¶ 33 Further, the fact that MAPA requires stenographic records in some instances is not sufficient to transform the WCC into a court of record for purposes of \( \text{§} \) \( \text{27-8-201}, \) \( \text{MCA} \). The WCC and other administrative tribunals may produce records which this Court or a *523 district court may review on appeal. However, courts that produce records are not the same as courts of record. The State correctly points out that if every administrative tribunal could transform itself into a court of record simply by producing records, the statutory limitations on the jurisdiction of courts of limited jurisdiction would be meaningless. Thus, lest there be any doubt, the WCC is not presently authorized to issue declaratory judgments under the UDJA and, more specifically, \( \text{§} \) \( \text{27-8-201}, \) \( \text{MCA} \).

¶ 34 Fourth, and lastly, the Workers maintain that if, as the State suggests, the Workers must challenge the constitutionality of workers' compensation laws in district court, the “practical effect of this solution” is to force them into “two separate courts; foster confusion between two courts; increase the likelihood of conflicting rulings; and compound time and expense for all litigants.” This argument also is without merit. If the Workers have “a dispute concerning any benefits”**876 under the Workers' Compensation Act, and if they wish, within the context of that dispute, to challenge “the applicability of any statutory provision or of any rule or order of the agency” on constitutional grounds, they may do so. Sections 2-4-501, 39-71-2905(1), \( \text{MCA} \). Therefore, as a factual matter, the Workers' fear of
being forced into two separate courts is simply unfounded. On the other hand, if the Workers wish to challenge the constitutionality of a statutory provision, rule, or order outside the context of a dispute concerning benefits, they must do so in district court. While the Workers contend that the “practical effect” of this scheme is to foster confusion between two courts, increase the likelihood of conflicting rulings, and compound time and expense for all litigants—a contention which is not supported by any evidence in the record—the statutory scheme is what the Legislature created, and conjectured savings in judicial economy cannot be a source of subject-matter jurisdiction.

¶ 35 For the foregoing reasons, we conclude that the WCC erred by concluding that it had jurisdiction to issue a declaratory judgment holding §§ 39-71-604(3) and 50-16-527(5), MCA, unconstitutional in the context of this case.

¶ 36 2. Did the WCC err when it awarded attorney's fees and costs against the State?

[12] ¶ 37 The State argues that the Workers were not entitled to the attorney's fees and costs awarded by the WCC for either of two reasons: (1) because the decision of the WCC to enter a declaratory judgment holding §§ 39-71-604(3) and 50-16-527(5), MCA, unconstitutional must be reversed, or (2) because the WCC's authority to award attorney's fees and costs did not apply in this case.

[13] ¶ 38 The general rule in Montana is that absent a statutory or contractual provision, attorney's fees are not recoverable. Stanley, ¶ 72; accord Hoven v. Amrine, 224 Mont. 15, 17, 727 P.2d 533, 534 (1986) (“Attorney fees are allowed when they are provided for by statute or contractual provision.”). The WCC has authority to award attorney's fees and costs in cases when it “determines that the insurer's actions in denying liability or terminating benefits were unreasonable.” Section 39-71-611(1)(c), MCA. As the State points out, this is not such a case—not only because the State (as distinguished from MSF) is not an insurer, but also because this was not an action concerning benefits.

¶ 39 Apparently recognizing that § 39-71-611(1), MCA, did not authorize an award of attorney's fees and costs in this case, the WCC relied on § 27-8-311, MCA, which provides that “[i]n any proceeding under this chapter the court may make such award of costs as may seem equitable and just.” For the reasons set forth above, however, the WCC did not have jurisdiction to enter a declaratory ruling under the UDJA; thus, this case was not a proceeding under Title 27, Chapter 8, MCA. Accordingly, § 27-8-311, MCA, also was not authority for the WCC to award attorney's fees and costs in this case.

¶ 40 We conclude that the WCC erred when it awarded attorney's fees and costs against the State, and we therefore reverse the WCC's award of attorney's fees and costs.

CONCLUSION

¶ 41 In summary, we hold that the WCC erred in concluding that it had jurisdiction to issue a declaratory judgment holding §§ 39-71-604(3) and 50-16-527(5), MCA, unconstitutional in the context of this case. If the Workers wish to challenge the constitutionality of §§ 39-71-604(3) and 50-16-527(5), MCA, that challenge must be brought in district court. Likewise, we also reverse the WCC's award of attorney's fees and costs against the State.

¶ 42 Reversed.

We concur: KARLA M. GRAY, C.J., PATRICIA COTTER and JIM RICE, JJ.
MIKE SALVAGNI, District Court Judge sitting for Justice BRIAN MORRIS.
Justice W. WILLIAM LEAPHART dissenting.

¶ 43 I dissent.

**877** ¶ 44 The WCC has, on numerous occasions, adjudicated constitutional challenges to statutes under the Workers' Compensation Act (the Act). See e.g. Stavenjord v. Montana State Fund, 2003 MT 67, 314 Mont. 466, 67 P.3d 229; Rausch v. State Compensation Ins. Fund, 2005 MT 140, 327 Mont. 272, 114 P.3d 192; Reesor v. Montana State Fund, 2004 MT 370, 325 Mont. 1, 103 P.3d 1019; Bustell v. AIG Claims Service, Inc., 2004 MT 362, 324 Mont. 478, 105 P.3d 286; Schmill v. Liberty Northwest Ins. Corp., 2003 MT 80, 315 Mont. 51, 67 P.3d 290. In the majority opinion, this Court cites to §§ 2-4-501 and 39-71-2905(1), MCA, as controlling in this case, holding that if injured employees “wish to challenge the constitutionality of a statutory provision, rule, or order outside the context of a dispute concerning benefits, they must do so in district court.” ¶¶ 25, 34.
¶ 45 First of all, the entirety of the Court's opinion is based upon a false premise—that is, the constitutional issue posed does not involve “benefits.” At issue is the constitutionality of § 39-71-604(3), MCA, which provides that the filing of a claim for “benefits” authorizes an insurer to communicate with a physician or health care provider about “relevant” health care information and to receive such information “without prior notice to the injured employee.” Obviously the issue does involve “benefits.” The issue of whether insurers obtain medical information directly from doctors without knowledge of a claimant can only arise if a claimant has filed a claim for benefits. While there is no claim for benefits in this specific declaratory action, the action arose when Workers, in pursuit of their individual claims for benefits, realized their right to privacy was being compromised. Leaving their individual benefit claims separate, they filed suit together to protect their own right to privacy, and to pave the way so that others can file for benefits without having to sacrifice their constitutional right to privacy. The WCC has jurisdiction to address issues which arise after benefits have been determined, i.e., fees and costs. See *Kelleher Law Office v. State Comp. Ins. Fund*, 213 Mont. 412, 417, 691 P.2d 823, 825 (1984). Why then would the same court not have jurisdiction to address the statutory hurdles to obtaining benefits in the first instance? Benefits are indirectly, if not directly, involved in both instances.

¶ 46 Even if one assumes the Court's ostrich approach and pretends that the statutes at issue do not involve benefits, the Court is wrong in concluding that § 39-71-2905(1), MCA, limits the WCC to cases which directly involve claims for benefits. While the Court's holding does not call into question the validity of the above cases, it incorrectly interprets § 39-71-2905(1), MCA, which gives the WCC exclusive jurisdiction of any dispute arising under the Act with only two exceptions.

¶ 47 *Section 39-71-2905(1)_, MCA, provides in whole:

*A claimant or an insurer who has a dispute concerning any benefits under chapter 71 of this title may petition the workers' compensation judge for a determination of the dispute after satisfying dispute resolution requirements otherwise provided

in this chapter. In addition, the district court that has jurisdiction over a pending action under 39-71-515 may request the workers' compensation judge to determine the amount of recoverable damages due to the employee. The judge, after a hearing, shall make a determination of the dispute in accordance with the law as set forth in chapter 71 of this title. *If the dispute relates to benefits due to a claimant under chapter 71, the judge shall fix and determine any benefits to be paid and specify the manner of payment. After parties have satisfied dispute resolution requirements provided elsewhere in this chapter, the workers' compensation judge has exclusive jurisdiction to make determinations concerning disputes under chapter 71, except as provided in 39-71-317 and 39-71-516. The penalties and assessments allowed against an insurer under chapter 71 are the exclusive penalties and assessments that can be assessed by the workers' compensation judge against an insurer for disputes arising under chapter 71.*

(Emphasis added.) Pursuant to this statute, the WCC has jurisdiction of disputes concerning any benefits after dispute resolution requirements are met. The statute then provides**878* that *if the dispute relates to benefits due, the workers' compensation judge must fix the amount. The fact that the legislature included the words “if the dispute relates to benefits due” indicates that the legislature contemplated non-benefit related disputes to be handled by the WCC if they arose under the Act. In fact, the legislature went on to provide that the workers' compensation judge has *exclusive* jurisdiction to make determinations concerning disputes (“disputes” having no qualifying language about benefits this time) under the Act, with only two exceptions, neither of which are applicable here. The statute does not exclude constitutional challenges from the jurisdiction of the WCC if the challenges concern the Act.

¶ 48 This Court has previously held:

*[T]he contention that the Workers' Compensation Court has no declaratory power is not in accord with the provisions of the statute nor the provisions of the Montana Administrative Procedures Act.

Although the Workers' Compensation Court is not vested with *527* the full powers of a District Court, it nevertheless has been given broad powers
concerning benefits due and payable to claimants under the Act. It has the power to determine which of several parties is liable to pay the Workers' Compensation benefits, or if subrogation is allowable, what apportionment of liability may be made between insurers, and other matters that go beyond the minimum determination of the benefits payable to an employee.

State ex rel. Uninsured Emp. Fund v. Hunt, 191 Mont. 514, 519, 625 P.2d 539, 542 (1981). As an extension of this logic, this Court has held that the “extended jurisdictional authority of the [WCC] includes payment of attorney's fees and related costs.” Kelleher Law Office, 213 Mont. at 415, 691 P.2d at 825. In the case at hand, the Workers brought a constitutional challenge to a statute under the Act that conditions a claim for benefits on the waiver of the claimant's right of privacy in his or her medical records. Recognizing that the WCC has jurisdiction to handle such cases makes sense when one considers that our "district courts have not been concerned with workers' compensation benefits since the establishment of the Workers' Compensation Court in 1975." Ingraham v. Champion Intern., 243 Mont. 42, 49, 793 P.2d 769, 773 (1990). I have no doubt that if the Workers had brought their claim in district court, it would have been dismissed for lack of jurisdiction.

¶ 52 It is clear that the power to issue a declaratory judgment is reserved to courts of record. The WCC is not a court of record. *§ 3-1-102, MCA. Thus, the WCC had no jurisdiction to issue its declaratory judgment and the Court is correct that such judgment must be reversed and this action dismissed.

¶ 53 However, I do agree with Justice Leaphart that the present action involves "benefits." Had the WCC issued its opinion in a controversy involving a particular claimant, and not in a declaratory judgment action, it would have had jurisdiction to determine whether the disclosure provisions in §§ 39-71-604(3) and 50-16-527(5), MCA, violated**§ 879 their constitutional rights and to consider and award attorney fees.

¶ 54 Thus, I concur with the result of this case, but disagree with much of the Court's rational.

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