Prognosis

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The Chair's Comments

Sissy Holloman

The 2013-2014 year has been extremely busy and very productive for the Health Law Section. The Health Law Council held its February meeting at Wake Forest Law School, with a very large student turnout. We continued and expanded our practical education program for law students this year with sessions for UNC, Elon, Central and Wake Forest Law Schools on "What Every First Year Associate Needs to Know About a Health Care Transaction." Plans are in the works to bring the session to Charlotte and Duke in the fall. This is a great way to connect with budding lawyers and to provide some practical advice.

Our focus in recent years has been pro bono projects associated with advance directives and other needs associated with critical illness:

- Members of the Health Law Section have participated in the Cancer Center Pro Bono Legal Project, a joint initiative of Duke and UNC law schools and the cancer centers associated with their hospitals. Sessions are held by law students, supervised by practicing attorneys, to educate patients at the cancer centers about their rights and to assist in creating advance directives. In the fall, Novant Health Forsyth Medical Center partnered with WFU School of Law and Womble Carlyle to offer the Cancer Pro Bono Project to patients at its Cancer Center. WFU expanded to include Baptist in February 2014. Plans are underway to offer a similar program starting in the fall of 2014 at Presbyterian in Charlotte in collaboration with the Charlotte School of Law.
- Over the past few years, the End of Life Public Awareness Committee of the Health Law Section has spent many hours creating a very helpful public website (***www.AGiftToYourFamily.org***) with

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Nonprofit Hospital Director Liability Protections: Worth A Second Look

By John B. Garver III, Karen A. Gledhill and Amit Bhagwandass

The recent decision in which Tuomey Healthcare System, a mid-sized community nonprofit hospital, was ordered to pay damages of $237 million for Stark law violations likely will prompt independent trustees and directors of nonprofit hospitals to assess their personal exposure for board service. **U.S. ex rel. Drakeford v. Tuomey**, CA 3:05-2858-MBS, 2013 WL 5503695, (D.S.C. Oct. 2, 2013). Although **Tuomey** was a decision against a hospital, and no board members were named as defendants, the South Carolina Attorney General was asked to opine concerning the hospital's indemnification for its directors. This article discusses the North Carolina Nonprofit Corporation Act's (N.C.G.S. § 55A) provisions for immunity and indemnity as well as the use of directors and officers (D&O) insurance as a last line of defense to a lawsuit against a hospital board member.

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NORTH CAROLINA BAR ASSOCIATION
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The Chair's Comments, *continued from the front page*

many valuable resources for end-of-life planning. This project concluded this spring with the completion of the website, DVD, public service announcements and e-courses, and associated promotion of the website and related materials. This project would not have been possible without the efforts of Ken Burgess, Melanie Phelps, and Chuck Hollowell. At our annual meeting, the Health Law Section recognized the tireless work of these individuals to make this project such a success.

- In February, an enthusiastic group came to the Health Law Section's "Summit on Pro Bono Efforts related to Critical Illness" to discuss our current pro bono projects and to provide ideas for future projects. The group proposed, and the Council approved, an expanded "signature" pro bono project for the Health Law Section which would be similar to "Wills for Heroes" – staffing semi-annual "clinics" throughout the state on advance directives using Bar members to help explain advance directives and to help complete these documents. We are planning to launch a pilot in November of 2014. If you are interested in participating in this new project, please contact a Council member.

The 2014-2015 term begins this summer with new Chair - Jim Wall, Vice-Chair- Joe Kahn, Secretary- Kim Licata, and Treasurer- Jennifer Hutchens; and new Council members: Sarah Coble, Lori Jessee, Michael Murchison, Melissa Phipps, Jennifer Schenk and Blakely Kiefer. I have thoroughly enjoyed my time as Chair and want to thank all of you for your great ideas and support throughout this past year. I hope you will continue to be involved in the Health Law Section in the upcoming year.

NCSHCA – President's Report (June 2014)

By Marc C. Hewitt

Marc Hewitt

Here in downtown Raleigh, the short session of the North Carolina General Assembly is underway, and it is hard to escape the debate and speculation by lawyers and our clients about the impact of potential new legislation. The concentration of attention serves as a reminder that, despite pervasive federal law and regulation, healthcare in North Carolina is also largely shaped by our state's unique legislative and regulatory environment. Accordingly, in 2014 the North Carolina Society of Healthcare Attorneys continues its focus on North Carolina-specific healthcare issues and topics, and we have several exciting projects and upcoming events in keeping with this theme.

Annual Meeting and Conference – Sept. 19, 2014

First, please join us for our Annual Meeting and Conference which will be held again this year at the Rizzo Conference Center in Chapel Hill. The Annual Meeting offers great networking and a full day of CLE (including one hour of substance abuse CLE!) with several North Carolina-centric topics, including:

- Medicaid Reform panel discussion - including members of the Governor's Medicaid transition team and the Medicaid Reform Advisory Group
- Certificate of Need Reform
- Legislative and Case Law Updates

N.C. Healthcare Law Writing Competition

The Society also has a writing competition in the works open to current law students or 2014 graduates of North Carolina law schools. The author of the best submission on a healthcare topic relevant to North Carolina providers will receive a cash prize and publication. The submission date and other details will be decided soon, so please watch for an announcement.

Analysis of NC Administrative Decisions Project

In keeping with the Society's mission to educate North Carolina attorneys on healthcare law, we are working on a new project to provide analysis of healthcare-related decisions from the North Carolina Office of Administrative Hearings. OAH decisions are highly relevant to the healthcare community since OAH decides issues regarding licensure and certification of facilities, Medicaid issues, certificate of need appeals and others.

Although delayed access to selected OAH decisions is available via the OAH web site and Lexis, the Society is coordinating immediate access to new OAH decisions as they are released. We are exploring a project to provide a timely synopsis of relevant issues in healthcare related cases to be written by Society volunteers and posted online. Please contact Marc Hewitt at marc.hewitt@smithmoorelaw.com to volunteer to help track and summarize new decisions.

As always, we invite our members, and those interested in becoming members, to get in touch and get involved either by volunteering for one of our projects or committees or simply by joining and following our LinkedIn.com group. Thanks again to all our dedicated board and committee members, and we wish everyone a great summer.

Marcus C. Hewitt is an attorney with Smith Moore Leatherwood, LLP in Raleigh. He is president of the N.C. Society of Healthcare Attorneys.

Nonprofit, continued from the front page

Director Duties

Under North Carolina law, directors of nonprofit corporations must carry out their duties "in good faith," with "the care an ordinarily prudent person in a like position would exercise under similar circumstances," and "in a manner the director reasonably believes to be in the best interests of the corporation." N.C.G.S. § 55A-8-30(a).

The "ordinary prudent person" standard is the duty most likely to be at issue under a set of facts like **Tuomey**. The nature of the claim would rest on allegations that the directors, in the exercise of ordinary prudent care, should not have allowed regulatory violations to exist. To meet this standard, directors are required to be informed of the hospital's affairs and particular facts that will impact decision making on critical issues, *e.g.*, oversight of physician contracting. At a minimum, they must attend meetings, devote the time to understand the major issues, and properly discuss and deliberate before making a decision. Reliance on experts such as attorneys and accountants is authorized by statute, but not if the director's actual knowledge of the matter makes reliance unwarranted. N.C.G.S. § 55A-8-30(c).

Potential Claimants

The potential plaintiffs for a breach of duty claim are fairly narrow in scope. Standing to bring a derivative action is restricted to members and directors of the nonprofit corporation. N.C.G.S. § 55A-7-40(a). For example, a member of the nonprofit corporation could bring an action in the name of the corporation against the directors, claiming that they breached their duties to the corporation by failing to monitor regulatory compliance and to rectify any non-compliance. The complaint would allege that the corporation suffered damages as a result of such failure—for example, in a case like **Tuomey**, damages would be in the amount of unreimbursed services provided by the corporation where claims for federal reimbursement had been made and set aside. To date, there have been no reports, however, of member derivative actions in the wake of the **Tuomey** decision.

Another potential claimant is the state attorney general, who is authorized to bring legal action to dissolve the nonprofit corporation on the grounds, among others, that the directors are acting in a manner that is "illegal, oppressive, or fraudulent." In such an action, the attorney general may also ask the court to set aside corporate transactions that are *ultra vires* (or outside the powers of the corporation). *See* N.C.G.S. §§ 55A-3-04(b)(3), 55A-14-30. The statute authorizing the attorney general to bring an action for dissolution does not explicitly contemplate recovery of monetary damages, but it is easy to imagine a party asking the court to appoint a receiver for the corporation in the proceeding. Such a receiver could be empowered to bring legal actions in the name of the corporation, which would include actions against the directors for breaches of duties. N.C.G.S. § 55A-14-32.

Finally, the federal government could sue directors for civil monetary penalties. However, neither the board nor any officer was made a party to the **Tuomey** lawsuit. In a civil monetary penalties claim, the government would have to show that the director knew false claims were presented to the government or acted with gross negligence with regard to his or her conduct such that it constitutes reckless disregard for the truth. 42 U.S.C. § 1320a-7a. Perhaps, if the corporation is solvent, the government may reasonably conclude that its burden of proof is not as onerous if it sues only the corporation, and there is no economic incentive to shoulder the higher burden to pursue directors.

The directors in **Tuomey** may have escaped liability for many reasons, including the possibility that they performed their duties in a manner that is not reasonably subject to challenge. But **Tuomey** certainly prompts questions about the potential avenues for director liability and to consider whether they have appropriate protection. There are a number of layers that a director might rely on to shield herself from personal liability, either for defense costs or for a judgment. The first of these is immunity or exculpation, which may act as a legal defense to the claim, but does nothing to assist with defense costs. The second is indemnity, either mandatory or permissive. Indemnification may help provide a defense and pay a judgment, depending on the circumstances. Finally, there is D&O insurance, which can be useful on multiple fronts. A more detailed discussion of each follows.

Exculpation

The hospital's articles of incorporation may limit or eliminate a director's personal liability "for monetary damages arising out of an action whether by or in the right of the corporation or otherwise for a breach of any duty as a director." N.C.G.S. § 55A-2-02(b)(4). This exculpation provision, if included in the articles of incorporation, is subject to certain limitations, the most important of which is that the director may not escape liability for acts if the director knew or believed at the time that the action was "clearly in conflict with the best interests of the corporation" or "if the person received an improper personal financial benefit." The commentary to the section states that such exculpation is *only* available in derivative actions, meaning relief from third party claims should be available only under the immunity provisions of N.C.G.S. § 1-539.10 and N.C.G.S. § 55A-8-60.

Immunity

North Carolina law grants immunity to nonprofit directors from civil liability for monetary damages, subject to a number of limitations. N.C.G.S. § 55A-8-60. Stated briefly, even if a nonprofit hospital's articles and bylaws are completely silent on exculpation/immunity, this statute provides immunity to nonprofit directors in certain circumstances.

To gain this immunity the director must be uncompensated. Additionally, the director must have been acting in good faith, within the scope of her official duties, must not have committed gross negligence or willful or wanton misconduct, and must not have derived an improper personal financial benefit from the transaction in question. A director might also seek to rely on the general immunity for charitable volunteers provided under N.C.G.S. § 1-539.10; however, immunity is not available for gross negligence or wanton conduct, so the potential scope of the immunity would not vary materially from that of N.C.G.S. § 55A-8-60. N.C.G.S. § 55A-8-60's protections for uncompensated nonprofit directors are not replicated in the North Carolina Corporations Act; however, in nearly all instances discussed below, the Nonprofit Corporations

Act closely tracks the provision governing for profit corporations, except that the former requires that the director not have derived an improper personal *financial* benefit.

Mandatory Indemnification

Nonprofit directors can obtain further protection through indemnification by the corporation. Unless the corporation's articles of incorporation state differently, directors have the right to be indemnified if they are "wholly successful" in the defense of a lawsuit. N.C.G.S. § 55A-8-52. While this indemnification is called "mandatory" in the statute, it technically is not, because there is the possibility, albeit unlikely, that this indemnity could be circumscribed under the articles of incorporation. This indemnification would only be available at the close of a successful defense and would not cover defense costs as they occurred during the pendency of the lawsuit.

Permissive Indemnification

The corporation may grant additional protection to the directors by providing for indemnification even if the director is not "wholly successful" in the litigation. The requirement for this type of indemnification is that, if the director is made a party to the litigation as the result of conduct in the director's official capacity, the director must have acted in what he "reasonably believed" to be in the "best interest" of the corporation. If the director is brought into an action on any other grounds, the person must have reasonably believed that "his conduct was at least not opposed to its best interests." In a criminal proceeding, the director must have had "no reasonable cause to believe his conduct was unlawful." N.C.G.S. § 55A-8-51(a)(3).

Expanded Indemnification

The standards for indemnification described above are common in many states. North Carolina has a third type of indemnification that is even more protective of directors, generally known as "expanded indemnification." N.C.G.S. § 55A-8-57. North Carolina nonprofit directors may be indemnified for their actions (if the articles of incorporation or bylaws provide), subject to the limitation described above for exculpation. That is, the director will only lose a right to indemnification if the person knew or believed at the time that the acts or omissions giving rise to liability were clearly in conflict with the best interests of the corporation or the director received an improper personal benefit.

The indemnification rules and the limitations on permissive indemnification are complex, but for the purposes of the **Tuomey** discussion, it is worth noting that the limitations all bear on the "best interests of the corporation" standard for directors' actions. The directors presumably would meet this standard in an action similar to **Tuomey**, unless they actually were acting in bad faith or with actual knowledge that their acts were illegal. Thus, generally the protections afforded to directors by exculpation and indemnification should be available.

Additionally, nonprofit hospitals may authorize, in their articles or bylaws, provisions for the advancement of litigation expenses. N.C.G.S. § 55A-8-53. This statutory section also authorizes advances of defense costs if approved by the board of directors. Such authorization often is included in the bylaws so that directors know in advance that they are entitled to this protection. Advancement of litigation expenses is very important, because such expenses may be ruinous—even if the director ultimately is not held liable. In this situation, a director must execute an undertaking to repay the advances unless it is later determined that the director was entitled to indemnification.

If a hospital wishes to provide maximum protection for its board members, its articles and/or bylaws should provide for exculpation, immunity, and indemnification of the directors to the fullest extent of the law. It may not be appropriate to extend that protection automatically to officers. Officers devote their efforts full-time to the corporation and may reasonably be held to a higher standard than that imposed on part-time directors. A more measured approach would be to make indemnification of officers in such a case optional at the discretion of the board of directors.

Enforcement of Indemnification Rights

North Carolina law provides that a director may enforce her right to indemnification through the courts and sets out a process for that to occur. N.C.G.S. §§ 55A-8-54, 55. Except as otherwise set forth in the hospital's articles of incorporation, the court should order indemnification if it determines the director is fairly and reasonably entitled to indemnification in light of all of the relevant circumstances.

D&O Insurance

The hospital's D&O policy can form the last line of defense when other protections fail. For example, a hospital may be willing to pay indemnification, but may not have adequate funds or may be insolvent. In the case of an uncompensated director, because the immunity granted by North Carolina law goes to monetary damages only, the costs of defending a lawsuit, even one without merit, may fall upon the individual director. Alternatively, a "new" board may be unsympathetic to the plight of former directors and may decline to provide permissive indemnification, or may renege on an obligation to indemnify (though such an about-face can be prevented by a well-drafted indemnification provision). For all these reasons, hospital board members should take the time to review their D&O coverage carefully.

Unlike exculpation, immunity, and indemnification, there is no limitation under North Carolina as to the permissible scope of D&O coverage. Additionally, conduct that could prevent a director from obtaining indemnification might not trigger the D&O policy's conduct exclusions. Those exclusions typically require a director to have committed a deliberately fraudulent act or omission or a willful violation of a statute or regulation. It seems unlikely that a D&O policy's conduct exclusions would be triggered under a set of facts like **Tuomey.** As noted earlier, the government's decision not to charge any individual directors or officers in **Tuomey** may suggest that those individuals did not act deliberately to commit fraud or willfully violate the applicable regulations.

There are a number of good sources of advice on negotiating D&O coverage. *See* Stephen Allred, *Key Issues in Evaluating and Negotiating D&O Coverage*, Notes Bearing Interest (forthcoming May 2014). We will not attempt to duplicate them here, although we will discuss certain points of particular relevance to an individual director's review of a D&O policy. For instance, the conduct exclusions referred to above must be made subject to a "final non-appealable adjudication" standard. The insurer should not be

able to invoke these exclusions unless there has been a final and non-appealable adjudication, in a proceeding not brought by the insurer, which is adverse to the director and finds a deliberately fraudulent act or omission or willful violation.

Additionally, the conduct exclusions may apply differently to individual directors. The knowledge of one individual insured should not be imputed to another when evaluating the reach of the conduct exclusions. Likewise, the policy should include language that the insurance application will be construed as a separate application for each insured person. In that manner, a misrepresentation by the hospital CFO on the application will not be imputed to any individual director, unless the director knew the facts that were not truthfully disclosed.

Directors want an assurance that there will be funds available to pay defense costs and judgments. This could become a problem if policy proceeds are siphoned off to pay other amounts due under the policy. The bankruptcy of the hospital (as could be caused by the damages awarded in the $237 million **Tuomey** verdict) also might have ramifications for the directors, as would that of the insurer itself.

A hospital's protection of its directors, even in the event of a hospital bankruptcy, can be achieved several ways. The clearest protection comes from obtaining a separate "Side A" policy that only covers directors. The proceeds of such a policy are not part of the bankruptcy estate. Further, a separate Side A policy's limits will not be eroded by anything other than defense costs and judgments. For example, they won't be used to pay the hospital's costs of responding to a *qui tam* relator's lawsuit.

Short of a separate Side A policy, there remain options to ensure protection in the event of bankruptcy or the erosion of limits. The first step is to make certain that your D&O policy contains a priority of payments scheme under which the coverage for directors (also generally termed "Side A" even in a mixed coverage policy) first pays Side A, and only after that may it be used to reimburse the hospital for indemnity payments or for the hospital's own damages.

Directors also should push for language that, in the event of a bankruptcy, explicitly waives the automatic stay and confirms that the hospital will not oppose efforts of the insurer to obtain relief from any stay or injunction. This is important so that the bankruptcy trustee will not be able to claim the policy proceeds (at least the part that ought to be available to the directors) as part of the bankruptcy estate. Preventing a trustee from successfully making this argument not only provides monies to pay judgments, but perhaps more importantly, keeps advances for defense costs flowing, which is a more immediate and common need than paying an adverse judgment.

The quality of the insurer is critical. The insurer should have a satisfactory A.M. Best rating. The insurer also should be a standard player in the D&O field. The hospital's insurance broker will be able to assist here. A cut-rate policy may appeal to the hospital's CFO, but will not hold the same appeal for a director after a claim has been made. The difference in premiums should not be significant and is not worth the difference in protection.

One final critical point worth mentioning is the need for the insurance broker and the lawyer reviewing the policy to coordinate their efforts. Each brings different skills and focus to the process. Lawyers are good at drilling down into the fine print. Brokers know the market and the products. Bringing those separate disciplines together will create a sum greater than its parts.

Quick Takeaways

- Review the immunity and indemnity provisions in the hospital's articles and bylaws.
- Revise the bylaws to offer directors immunity and indemnification to the "fullest extent of the law."
- Ask for a separate "Side A only" policy for director coverage.
- Negotiate for a "priority of payments" clause in your D&O policy.
- The hospital's attorney and its insurance broker should work together to review, and if necessary, improve D&O coverage.

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The Affordable Care Act – A Mid-2014 Update

By Justin M. Puleo

Implementation Status

It has been a very significant year thus far for the implementation of the Affordable Care Act (the "ACA"). Thanks to exhaustive media coverage, most Americans are well aware that the individual mandate has taken effect, insurance coverage is now available through the government-run website (www.healthcare.gov), and Medicaid has been expanded in 26 states. In addition, according to the Kaiser Family Foundation, 13 additional provisions have been put into place this year. They include guaranteed availability of insurance, no limits on coverage, requirements for essential health benefits, medical loss ratios for Medicare Advantage Plans, wellness program participation rewards, and reductions in Medicare payments to hospitals for nosocomial infections, to name a few.

These developments mark significant progress for a law often considered unwieldy, but it has been a very rocky road getting to this point. A Supreme Court challenge, partisan rancor spanning five election cycles, seemingly endless delays, and a disastrous rollout of open enrollment through ***healthcare.gov*** in the fall of 2013 eventually led to the resignation of Department of Health and Human Services Secretary Kathleen Sebelius. Even with all of these challenges, the bulk of the law remains intact and is moving forward.

Enrollment Figures

At its core, the ACA has two primary aims: to increase access to health care and reduce rising health care costs, sometimes referred to as "bending the cost curve." If measured by increasing access alone, the ACA has been successful. Strong enrollment figures have taken the wind out of the sails of many campaigning on a platform of full repeal. On May 2, 2014, Kathleen Sebelius announced that "about 20.8 million people are now enrolled in insurance because of the law." The 20.8 million number includes 8 million enrolled through the exchange, 4.8 million now covered by Medicaid and CHIP, 5 million who bought coverage outside the exchange, and 3 million young adults now covered under their parents' plans.

Of course the success of the ACA as to its second aim, bending the cost curve, remains to be seen. Some commentators anticipate premium rate shock for 2015, but the Obama Administration has been adjusting the risk corridor provisions of the ACA to increase financial protections for insurers that may find many of the newly insured consumers sicker and older than their previous customers. In North Carolina, data from the exchange enrollment described a population that skewed in favor of female, older, and financially needy consumers. Plans sold on the exchange have a fixed affordability measure, which means that premiums cannot be more than 9.5% of household income. If health insurance costs continue to rise, subsidies will have to increase as well. When the ACA was originally drafted, employer mandate penalties were earmarked as the source of this subsidy funding; however, the employer mandate has been delayed several times and this funding gap has not been addressed.

Options for Employers in 2015

The employer mandate delay was caused in part by widespread bipartisan requests to make the mandate more manageable and to provide transition relief and additional guidance for complicated employment situations, such as seasonal employees, variable hour employees, and staffing firm employees. Additional guidance came on February 12, 2014, in the form of the ACA's Final Regulation on the Employer Shared Responsibility Provisions. In a new development, the government gave additional relief to mid-size employers by creating a new category of employers with 50 to 99 full-time equivalent ("FTE") employees and delaying their required compliance until January 1, 2016. Employers with 100 or more FTE employees must still comply in the first year in order to remain compliant. However, by January 1, 2015, they are only required to offer affordable, minimum value insurance to 70% of their workforce, as opposed to the originally required 95%.

The Obama Administration is seeking buy-in from employers to help ensure the success of health care reform. If employers are forced to adapt to the new mandate too quickly, commentators fear that employers will get out of the health coverage business altogether, opting to pay the penalty, rather than provide health coverage. Although the penalty may cost less, it does not add value to an employer and may hurt a company's ability to retain and recruit talent. While 2015 brings some flexibility for large employers, it will also bring more attention to the Small Business Health Options Program ("SHOP") exchange for small employers. Online SHOP enrollment was delayed one year to focus on the individual market component of healthcare.gov. SHOP is available to employers with fewer than 50 FTEs, who are able to shop for and provide health care coverage for their employees, potentially receiving tax incentives to do so.

While questions still remain about the ACA's implementation, and additional changes are likely, health reform is now part of the public consciousness. The pressures and challenges that created the ACA will continue to be at the center of discussions surrounding its implementation and the future of health care.

Justin M. Puleo is an associate with Smith Moore Leatherwood LLP focusing his practice on health care regulatory, transactional, and litigation work. He counsels hospitals and other health care providers, large and small, on a wide array of matters, including those related to the Affordable Care Act, drawing from his experience as an HHS Certified Marketplace Navigator. Mr. Puleo is resident in the Raleigh office of Smith Moore Leatherwood and may be reached at 919.755.8802 or ***justin.puleo@smithmoorelaw.com***.

Frankly Speaking: Talking Points When Counseling Clients on Completing North Carolina Advance Directives

By Barry K. Shuster

"So what we should plan is the living. Living until we die: what is most important to us; what is less important to us; situations that are acceptable; situations that are not acceptable. That's the plan I am talking about."-- Sarah H. Kagan Ph.D., R.N.

Prior to completing education and training as a bioethicist, I approached advance directive counseling as well as could be expected, being a lawyer without any particular experience or special insight on how these documents might come into play in the clinical setting. Typically, this involves emotionally-charged situations in which health care providers and family members are faced with difficult decisions regarding continuation or withdrawal of life-prolonging treatment measures.

I don't think I was unique in this regard. Nor do I think my clients were unique in their lack of preparation to consider their wishes in an unimaginable medical moral crisis. Estate planning attorneys routinely offer the completion of advance directives as part of a "package" that includes wills, trusts and durable powers of attorney. However, given the importance that advance directive documents will have at the end of life, there are some important points of discussion that every attorney should consider having with their clients when advising them on completion of these documents.

Prior to stepping into an attorney's office, a married couple who seeks to draft their wills is likely to have given some thought to the manner in which their assets should be passed to their heirs and, perhaps, who should be appointed as guardian(s) of their children if one or both of them dies. They are much less likely to have considered circumstances in which they become seriously ill or injured, sustained by medical technology with an uncertain or discouraging prognosis for recovery, and unable to express their wishes.

Indeed, most adults avoid or ignore these decisions. A 2008 U.S. Department of Health and Human Services report estimated that among the general adult population only about 18–36 percent of all adults had advance directives in place. End-of-life health care planning advocates have taken positive steps to increase public awareness of the importance of end-of-life planning, and to help individuals complete them.

Mass-distributed video productions such as "Consider the Conversation" (***http://www.considertheconversation.org***) have raised awareness of end-of-life planning. At local levels, *pro bono* legal projects seek to promote advance directive planning and assist people in completing the appropriate documents. A fair amount has also been written by lawyers for lawyers to explain the North Carolina living will and health care power of attorney documents. (*See,* for example, "Realizing the Promise of Advance Directives: A New Option for North Carolinians," *Prognosis*, February 2014).

As lawyers, we should bear in mind that these documents come into play in hospital settings often involving family and even clinician moral distress. Clinician frustration with the effectiveness of advance directives in practice, particularly the living will, is well-documented. As noted by ethicist-physician Robert Orr, M.D., "The primary problem with living will-type advance directives is that the condition encountered is often not included in the wording. Or, the person may refuse an option while writing about a theoretical situation that, in fact, the person might accept when faced with the reality of that situation." Orr, Robert D., "Medical Ethics and the Faith Factor," Cambridge UK;Wm. B. Eerdmans Publishing Co., 2009.

The North Carolina statutory living will and health care power of attorney forms can provide effective guidance at the end of life with proper attorney counseling. This article will attempt to provide practical "talking points" for attorneys who counsel clients on completion of advance directives so that these documents can be as effective as possible in the unfortunate event they are required.

North Carolina law provides statutory forms for both the living will (N.C.G.S. § 90-321(d1)) and health care power of attorney (N.C.G.S § 32A-25.1). There is no legal requirement to use the North Carolina statutory forms, though as a matter of practice, many attorneys utilize them. In fact, as the aforementioned February 2014 issue of *Prognosis* reported, health care providers and their advisors in North Carolina's Triad region recently joined efforts to modify the North Carolina statutory living will and health care power of attorney forms by combining them into a single, simplified advance directive form to make them as understandable and easy-to-complete as possible. This article would apply to counseling clients to complete this permutation of the North Carolina advance directive, as well as any other advance directive meeting the requirements of Article 23 of Chapter 90 of the North Carolina General Statutes (living will) or of Article 3 of Chapter 32A (health care power of attorney).

What's the Deal? | While most lawyers appreciate this fact, it is always worth remembering that many laypersons view legal documents with varying degrees of trepidation. Advance directives, which are attested to, notarized, and contain declarations that literally have life and death consequences, can be daunting, particularly to the client without much sophistication in legal matters.

Framing the purpose of completing advance directives in practical, non-legal terms, and explaining when the documents will become effective helps ease into a meaningful discussion. Completion of these forms, ideally, should be rooted in a larger conversation about the client's goals in order to avoid a perfunc-

tory exercise in which clients take a deep breath, check the boxes, and, fail to meaningfully consider their wishes at the end of life.

To understand fully the importance of the advance directive, clients and attorneys must appreciate that modern medicine seeks to honor patient "autonomy" as much as is possible and practicable. That advance directives give clients *control* when they are most vulnerable seems to resonate particularly with clients. Ideally, advance directives keep the clients "in the driver's seat" for their health care decisions when they are incapable of expressing their wishes.

Attorneys counseling clients on the completion of advance directives may also want to explain that advance directives are "springing" documents, which do not "spring" into play until a physician declares the patient "incapacitated" or unable to make or understand health care decisions on his or her own behalf. The client "signs away" nothing. As long as he or she has the ability to understand and appreciate the consequences of their decisions regarding their health care, and communicate them to caregivers, the advance directives remain dormant. While this may seem very basic to practicing attorneys, many clients are unaware of even the most basic points of law with respect to advance directive documents, and can benefit from a very practical discussion of these issues.

The client may also need to be advised regarding their right to cancel or change the provisions of their advance directive documents. The living will and health care power of attorney, like all estate planning documents, can be changed or voided at any time, as long as the declarant is competent. Assuring the client that they can change their mind and revoke their advance directives at any time, should they choose to do so, is appropriate and can be a source of comfort to some clients.

Who Is Your Agent? | Attorneys counseling clients on completion of advance directives may want to begin their discussion with the health care power of attorney. Framed in practical terms, this discussion will involve asking whether the client has one or more persons he or she would trust to "stand in their shoes" as a decision maker if they were incapacitated. This often serves as a good starting place for discussion, as this is arguably the most important decision for the client with respect to completion of their advance directive documents. A living will completed, perhaps, three, five or ten years ago might not be a true reflection of what the client would choose to endure medically today. A health care power of attorney document may grant the health care agent the power to revoke or override a previously-executed living will document. Thus, a genuine "surrogate" can be one of the most powerful allies for patients who cannot speak for themselves.

An agent appointed through a health care power of attorney has legal power to act on the principal's behalf with respect to health care decisions, to the extent specified in the document. An ideal health care "surrogate" is more than an agent; it is someone who knows the patient's concerns and values today, and who is committed to carrying out the patient's wishes (or best interests if such wishes are unknown), regardless of the surrogate's own values or beliefs. As Dr. Robert Orr notes in "Medical Ethics and The Faith Factor":

> "Once a surrogate is identified … he or she is expected to use substituted judgment in reaching a decision," Some people misunderstand this concept and think the surrogate is to substitute his or her judgment for that of the patient. Rather, it means the surrogate is to substitute a process to arrive at the decision that the patient would make, based on the patient's written or verbal expressed wishes, or an understanding of his or her wishes." *Id.*

Some clients already have a surrogate decision-maker in mind. Some clients will realize there is no person who fits that bill. And some will simply default to an individual without the appropriate level of consideration. It is the latter case, in particular, which a thoughtful attorney can help the client to avoid. Often, advance directives are completed along with wills and trusts by estate planning attorneys. In these cases, care should be taken to prevent persons named as executors and trustees from becoming default health care agents, without additional contemplation of the appropriateness of this designation.

For example, assume your client's eldest son in California is an accomplished and savvy executive and might be the natural choice to serve as executor of the client's will, even though he visits your client (a North Carolina resident) fairly infrequently. While probate and distribution of assets are business-type decisions and do not require immediate attention or insight into the decedent's values, serving as an effective surrogate requires knowledge of the declarant's wishes and values at the time of their incapacity. The client's youngest daughter, who lives near your client and visits him several times a week at his retirement community, might be a superior choice to her accomplished older brother, given her established and on-going communication and relationship with the client. End-of-life decision-making often requires the surrogate to be immediately available and often involves decisions that cannot be made remotely over the telephone. These situations may require detailed and difficult face-to-face conversations with the client's health care provider team.

One way to stimulate earnest consideration of who might serve as a health care agent for the client is to review with the client North Carolina's "statutory hierarchy" of decision-makers in the absence of a health care agent. North Carolina General Statute Section 90-322 sets forth the legally prescribed order of decision makers who may consent to withdrawal of life-prolonging measures for a person who lacks decisional capacity and has no living will:

- The patient's spouse.
- A majority of the patient's reasonably available parents and children who are at least 18 years of age
- A majority of the patient's reasonably available siblings who are at least 18 years of age
- An individual who has an established relationship with the patient, who is acting in good faith on behalf of the patient, and who can reliably convey the patient's wishes

If none of the above is reasonably available then, at the discretion of the attending physician, the life-prolonging measures may be withheld or discontinued upon the direction and under the supervision of the attending physician.

This statutory order might make perfect sense for the client;

however, in some cases, clients can immediately envision the disagreement and distress that could result with certain family members representing their wishes during a medical crisis. Even the closest of families oftentimes have complex dynamics and varying degrees of dysfunction. Loved ones may bring fear, guilt, personal values, and self-interest to the bedside, or may otherwise be overwhelmed by the circumstances.

It takes a special person to have a well-informed and reasoned conversation with health care providers on the continued course of treatment for a close relation, despite the emotional nature of the situation, and to make decisions that comport to their best understanding of the patient's wishes, even if they are difficult and painful, such as withdrawing care. That person might be a particular child or sibling, or even a close friend. A health care power of attorney puts that decision in the client's control. Therefore, it is vitally important to help your client carefully consider their best choice of surrogate(s).

Whomever the client selects as his or her health care agent(s) (the statutory form encourages listing as many as three, in order of preference), the client would be well-advised to share his or her concerns, opinions and values with the agent(s) regarding end-of-life care. This helps to assure that the agent(s) have a complete understanding of the client's wishes at the end of life, and have some basis to arrive at a decision that the patient would make for him or herself, if he or she had the capacity.

The Living Will | The North Carolina statutory living will avoids some of the inherent weakness of living wills as described above by Dr. Orr. For one, it clearly limits the situations in which the declarant can choose to request that his or her life not be prolonged "by life-prolonging measures" to incurable conditions with imminent death, likelihood of never regaining consciousness, and severe cognitive impairment. N.C.G.S § 90-321(d1).

While there are conditions that might not fit neatly into these descriptions, the language is not so broad as to include circumstances in which life-sustaining measures offer a chance for meaningful recovery. There are conditions, such as pneumonia and traumatic injury, in which a patient might only survive in the short term with the assistance of mechanical ventilation and artificial nutrition and hydration, but has reasonable likelihood of recovery.

Again, it is worth reminding the client that the living will springs into action only if a physician declares them incapacitated. Capacity is a serious medical diagnosis, and not taken lightly, which is why only a physician is licensed to make that determination.

The North Carolina living will creates some challenge for the attorney when the client must contemplate if he or she would want artificial hydration and nutrition ("tube feeding"), even though he or she wishes not to have other life-prolonging measures. Some clients will have no problem with this provision, based on some emotional or philosophical position, even if it is simply the notion that they do not like the idea of being dehydrated or starved, regardless of their medical condition. Others will ponder this provision quizzically. The basis for this decision has medical and religious implications that go beyond the scope of this article. However, it is worth mentioning that in some cases, it is medically prudent to withhold hydration and nutrition to reduce patient suffering, and that with proper "palliative" care (which the North Carolina statutory form living will references in the provision "I wish to be made as comfortable as possible") the patient likely would not experience hunger or thirst as we conceive it as fully functioning persons.

As a religious matter, hydration and nutrition might be excluded from the definition of medical treatment, but rather, may be considered basic human rights which should not be withheld under any circumstances. This idea has evolved in recent years, and can vary based on the patient's level of adherence to the tenets of his or her faith. Nevertheless, if a client has significant concerns about complying with the tenets of his or her faith, this is an issue he or she might want to discuss with a spiritual leader.

On that note, religious preferences often create complexities in end-of-life care decisions. Some of the issues are based on well-established religious doctrine, such as Jehovah Witness prohibitions against receiving blood transfusions. Others might be based on a patient's, or his or her family's, own concept (or even misunderstanding) of a certain faith.

Advance directives may be modified to include language referencing a particular religious authoritative figure to provide religious tenet guidance to the family or health care providers. For example, Orthodox Jews will execute "halachic" living wills, which designate a certain rabbi to consult on matters related to Jewish law. (Halacha is the collective body of Jewish religious laws.) In this case, the rabbi would not make end-of-life care decisions; rather, the rabbi would provide guidance on how Jewish law would approach a particular issue. These types of living wills are more likely to be encountered in states in which there are large Jewish populations. Catholic declarants might create something similar to designate a priest as a religious consultant.

If an attorney is serving devoutly religious clients for whom these matters are important, he or she might be well-advised to include language into the advance directives for his or her clients that would not conflict with the statutory requirements, but would provide a learned consultant to help family and health care providers navigate the declarant's belief system. In many cases, an expert in a particular religion can provide clarity and guidance in difficult circumstances, which would be welcomed by surrogates facing very difficult decisions at the end of their loved-one's life.

A provision of the living will form that is curious for some attorneys and clients is the section that prompts the declarant to direct his or her health care agent to follow the living will or gives the agent authority to make decisions that are different from what he or she has indicated in the living will. This naturally raises the question, "Why bother with the living will if I am allowing the health care agent to override my wishes?" There are several explanations in a practical sense. First, again, a living will is a snapshot in time, and a diligent health care agent might have reason to believe it does not accurately reflect the declarant's values at the time it springs into play, based, for example, on a more recent conversation with the declarant. Or, there could be unique medical circumstances in which the language of the living will does not provide clear guidance for health care decision makers. In these situations, it may be beneficial for the health care agent to have some flexibility in decision-making.

In other situations, the living will can provide the health care agent comfort in decision making. It is not uncommon for health

care decision makers to experience moral distress over instructions to withhold or withdraw life-prolonging measures, including "tube feeding," even though such measures may be futile in terms of achieving any meaningful recovery. In some cases, the decision-maker might even feel he or she is "killing" the patient, by authorizing the withdrawal of life-sustaining treatment in such circumstances. In these cases, the agent can lean on the living will to validate the wishes of the declarant, with which the agent might personally struggle, and not having the authority to override the living will provisions may actually provide comfort and certainty to the health care agent in their role as decision-maker.

As noted, the declarant can instruct the agent to follow the living will verbatim if he or she is adamant about the directives. In these cases, the agent and health care providers are obligated to abide by the living will as closely as possible. The client should bear in mind, however, if the language of the living will does not neatly address the particular circumstances, or if there is evidence that the executed document might not be an accurate reflection of his or her wishes at the time it comes into play, it can create conflict for all who are involved the client's health care decisions.

Clients who are struggling with a serious illness having a discouraging short-term prognosis, and who want to ensure absolutely that they are not sustained by intensive medical care, and/or are not resuscitated should they arrest at home or in a health care facility, might be advised to consider either a portable Do-Not-Resuscitate (DNR) or Medical Order for Scope of Treatment (MOST) form. These are medical orders that require execution by a physician, physician assistant or nurse practitioner; however, if clients are not aware of these forms, the attorney should at least be familiar with them so as to advise clients properly of their application.

It Usually Begins with the Lawyer | Bioethics, health care and legal communities are "getting out the word" about the importance of end-of-life health care planning and continuing to help make the process less intimidating. Nevertheless, the living will and health care power of attorney are legal documents best prepared with the assistance of attorneys. If advance directive public awareness efforts are to be as effective as possible, attorneys need to be effective in counseling their clients on advance directive completion.

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The Decreasing Significance of Quality in the Certificate of Need Review Process for Nursing Home Providers in North Carolina

By Brian Vick

For most of the history of North Carolina's Certificate of Need ("CON") law, N.C.G.S. § 131E-175, *et seq.,* the quality of care provided by nursing home applicants seeking a CON has played a relatively minor role in the review process and generated little controversy in subsequent litigation. However, in a recent review to allocate 240 new skilled nursing beds in Wake County (the "Wake County Review"), one unsuccessful applicant seized on the issue of quality and focused its litigation strategy on challenging the analysis used by the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Certificate of Need Section ("CON Section") to evaluate the applicants' conformity with N.C.G.S. § 131E-183(a)(20) ("Criterion 20").[1] At the contested case hearing, this strategy proved successful and resulted in a reversal of the CON Section's decision to deny the applicant a CON. **See AH North Carolina Owner LLC d/b/a The Heritage of Raleigh v. N.C. Dept. of Health and Human Svcs., Div. of Health Srv. Reg., Certificate of Need Section**, Case No. 12 DHR 08691, 12 DHR 08666, 12 DHR 08669 (June 20, 2013, N.C. Office of Administrative Hearings).

Although such success rested on arguments regarding the importance of ensuring that only providers with strong track records of providing quality care receive CONs, a recent decision in another nursing home review suggests that the actual significance of quality in nursing home reviews has diminished as a result of the Wake County Review, such that providers who previously would have been unable to obtain a CON due to quality deficiencies now no longer face an inevitable finding of non-conformity under Criterion 20.

Consideration of Quality in Nursing Home Reviews

Under North Carolina's CON law, nursing home providers must obtain a CON from the State before developing new skilled nursing beds. *See* N.C.G.S. § 131E-178(a). Although the General Assembly adopted numerous legislative findings to justify displacing

the free market for this and other "new institutional health services," N.C.G.S. § 131E-175, the CON law is most commonly justified on grounds of inhibiting the geographic concentration and overdevelopment of facilities. Ensuring the provision of quality care in regulated facilities is cited as an underlying goal of the law, N.C.G.S. § 131E-175(7), but the General Assembly did not design the law to achieve this goal in any meaningful way.

The only provision in the CON law that directly addresses quality is Criterion 20, which requires a CON applicant that is "already involved in the provision of health services" to "provide evidence that quality care has been provided in the past." N.C.G.S. § 131E-183(a)(20). Beyond this bare mandate to provide the requisite evidence, the General Assembly did not indicate what form such evidence should take or how such evidence should be judged in determining conformity with the statute. Until recently, in nursing home reviews, the CON Section resolved the ambiguity in Criterion 20 by placing narrow geographic, temporal, and substantive boundaries on its analysis of applicants' conformity.

Geographically, the CON Section only analyzed the quality history of existing nursing facilities that an applicant owned or operated in the county at issue in a given review. Thus, in a review to allocate new skilled nursing beds in Cabarrus County, the CON Section would only consider the history of the applicant's existing facilities in Cabarrus County. Temporally, the CON Section limited its analysis to events that took place during the eighteen months before a CON application was filed, as well as any that occurred during the review period.

Substantively, the CON Section narrowly focused its Criterion 20 analysis on survey deficiencies issued by the Nursing Home Licensure and Certification section that met the definition of "substandard quality of care" ("SQOC") under federal Medicare regulations. *See* 42 C.F.R. § 488.301. When an applicant owned or operated a facility that had received a SQOC deficiency in the relevant geographical area during the relevant time period, the CON Section applied a bright-line, zero-tolerance rule under which the applicant invariably was found non-conforming with Criterion 20, regardless of any circumstances surrounding the deficiency. Even if the applicant had a lengthy and unblemished track record for providing good quality care at the facility in question and other facilities throughout the State, a single SQOC deficiency would preclude the provider from obtaining a CON in the county where it had received the deficiency.

By narrowly focusing its Criterion 20 inquiry in this manner, the CON Section created an analytical framework that was clear, was easy to apply in a consistent manner, and ensured predictability across reviews. In any given review, a nursing home provider could accurately predict whether applying for a CON would be an exercise in futility simply by reviewing its survey history in the county at issue. However, the limitations that allowed such predictability created the potential for inequitable and arbitrary outcomes. Because the quality of care in any nursing home depends, to a large extent, on the performance of the staff in that facility, a provider would be foreclosed from the CON process in a given county for at least eighteen months if a single employee made a single mistake on a single day that resulted in a SQOC deficiency. Until the Wake County Review, no applicant had ever maintained a challenge to the CON Section's use of its historical Criterion 20 analysis in nursing home reviews through a full contested case hearing.

The Wake County Review

In August, 2011, nine applicants filed sixteen separate CON applications in response to a need determination for 240 new skilled nursing beds for Wake County. In January 2012, the CON Section issued a decision that divided the beds between three applicants and was promptly challenged by three of the disapproved applicants. The Criterion 20 issues in the case focused on two applicants, one which had been approved for a 120-bed CON and one which had been found non-conforming with Criterion 20 and denied a CON for the same number of beds. Both applicants operated an existing facility in Wake County, as well as numerous other facilities across the State. Both applicants had received SQOC deficiencies at facilities in the State, but only the disapproved applicant had received such a deficiency at a facility in Wake County. Under the narrow confines of its historical analysis, the CON Section found the approved applicant conforming with Criterion 20 and the disapproved applicant non-conforming.

At the contested case hearing, the Criterion 20 arguments largely revolved around the question of whether the CON Section should determine conformity using the type of narrowly-focused analysis it had historically employed, or whether it should analyze each applicant's track record for providing quality care using a broader and more holistic analysis. Advocates for the historical analysis focused on the certainty and predictability that it produced across reviews, as well as the practical difficulty of accurately and fairly judging something as subjective as "quality of care" on a more holistic basis. Advocates for the holistic approach focused on the need for reasoned consideration of each applicant's overall quality track record, as well as the potential for arbitrary and inequitable outcomes under the narrower historical analysis.

Ultimately, the ALJ resolved this tension in favor of the holistic approach and rejected the narrow geographic and substantive boundaries of the CON Section's historical analysis. In doing so, the ALJ ruled that the CON Section must determine conformity with Criterion 20 through a "meaningful analysis" of each applicant's track record of providing quality care statewide. **AH North Carolina Owner LLC d/b/a The Heritage of Raleigh**, Case No. 12 DHR 08691, 12 DHR 08666, 12 DHR 08669 at 64-65. Although the ALJ reversed the CON Section's Criterion 20 conformity determination for the disapproved applicant in the Wake County Review, the ALJ did not set forth the analysis used to reach such conclusion or adopt a specific standard to govern conformity determinations in future reviews. (The ALJ also reversed the conformity determination for the approved applicant, but did so for reasons that were primarily procedural, rather than substantive, in nature. *Id.* at 65-66.) Rather, the ALJ deferred the development of such a standard to the CON Section and its rulemaking authority. *Id.* at 69. Two of the applicants and the CON Section promptly appealed the ALJ's Final Decision to the Court of Appeals. That appeal was still pending before the court at the time this article was written.

The Chatham County Review

Shortly after the contested case hearing in the Wake County Review concluded, the CON Section began a new review of five applications filed in response to a need determination for 90 new skilled nursing beds in Chatham County (the "Chatham County Review"). The Cha-

tham County Review encompassed Certificate of Need Section Project I.D. Numbers J-10167-13 through J-10171-13. Because the Final Decision in the Wake County Review was under appeal at the time, the CON Section faced the task of conducting its Criterion 20 analysis based on an uncertain legal landscape. Although the CON Section had clear guidance on what it could not do in this analysis (e.g., focus on a single county), it lacked clear guidance on what it could or should do. Deprived of its ability to disqualify applicants using a bright-line test (i.e., a single SQOC deficiency), the CON Section was faced with the task of formulating an entirely new methodology that would both encompass a holistic statewide analysis of each applicant's operational history and produce consistent and dependable results.

Although the decision issued in the Chatham County Review in January 2014 clearly indicates that the CON Section formulated and applied a new methodology for the Criterion 20 inquiry, it does not provide any insight on the substance of this new analysis. Rather, for each applicant subject to Criterion 20 in the review, the findings simply stated that the applicant had "provided evidence that quality care ha[d] been provided in the past" and "demonstrated that there is no pattern of substandard quality of care," and, therefore, was conforming with Criterion 20. *See Required State Agency Findings,* Project I.D. Numbers J-10167-13 to J-10171-13 at 47-49 (February 3, 2014). For two of the applicants, this conclusion was particularly notable because each was found to be conforming even though it had received SQOC deficiencies within the relevant time period for the review, albeit none at existing facilities in Chatham County.

On its face, this decision says little about the role that quality of care plays in nursing home reviews following the Wake County Review. Because the CON Section did not delineate or describe the substantive standard that it is now applying, the decision does not provide any insight on what type of quality deficiency, if any, would be sufficient to trigger a finding of non-conformity under this new analysis. Whereas before an applicant had clear guidance on when a CON application would be futile, now an applicant has no basis to make such a determination. However, the mere fact that one of the applicants in the Chatham County review was found to be conforming despite having received SQOC deficiencies in nearly one-third of its facilities statewide clearly indicates that the relevance of survey deficiencies in the review process may have declined dramatically.

Previously, a nursing home applicant with a single SQOC deficiency, which fell within the parameters of the Criterion 20 analysis, faced an inevitable finding of non-conformity. Now, an applicant with as many as six SQOC deficiencies spread across five facilities does not necessarily face the same fate. Thus, quality deficiencies have far less significance to and impact on the CON review process under the standards adopted by the CON Section following the Wake County Review than they did under the narrower historical analysis. Although the substantive boundaries of these new standards are not yet evident, they are manifestly lower than they were previously, given that survey deficiencies no longer trigger automatic exclusion from the CON process in a given area for a nursing home provider when considered as part of the CON Section's Criterion 20 analysis.

What does the future hold?

At present, the Criterion 20 issues discussed in this article are in legal limbo. The Wake County Review is before the Court of Appeals and the Chatham County Review is before the Office of Administrative Hearings. Either individually or in combination, these cases will – or, at the very least, should – provide substantial clarity on how Criterion 20 will be applied in nursing home reviews. Although the Criterion 20 issues in the Wake County Review are, to a large extent, specific to nursing home reviews because of the ALJ's underlying legal analysis, the outcome of the pending appeal should also shed light on how Criterion 20 likely will be applied for other health services. Regardless, now that Criterion 20 has proven to be an effective weapon in CON litigation, one can reasonably assume that similar arguments and challenges will arise with greater frequency across the full spectrum of CON reviews.

Brian Vick is a partner practicing health law in the Raleigh office of Williams Mullen. His practice is focused primarily on representing health plans, hospitals, pharmacies, and long-term care providers in administrative, regulatory, and legal disputes.

1 The author of this article represents one of the nursing home providers in the Wake Count Review for which Criterion 20 was an issue and participated in the trial discussed herein.

Tribute to Barbara Garlock

By Todd Hemphill and Melissa Phipps

Barbara Bosma Garlock, former health care lawyer and Health Law Section president during 1999-2000, passed away on June 23, 2013, after a six and a half year battle with breast cancer. She was a brilliant lawyer and patient rights advocate, whose contributions were not limited to her professional life. Incorporating her strong beliefs in social justice and education, Barbara fearlessly mobilized for the health, economic and social needs of others as a leader for cancer support groups, public schools and in the Methodist Church. In the past few years, she began the Bread for Our Neighbors Summit and volunteered as a Stephen Ministry counselor and as a Wake County Schools Character Education coordinator. Over the past several decades, Barbara served on regional boards for Women N.C., Triangle Family Services, the Multiple Sclerosis Foundation, American Cancer Society, and on the N.C. Methodist Conference Board of Church and Society. Barbara's dream was to start a Center for Patient Partnerships, helping people navigate our broken health systems. In the meantime, she mentored countless colleagues, young people, other persons facing life-threatening cancer, and spiritual seekers. Earlier this year, her friends dedicated a bench in her memory at the Hemlock Bluffs State Nature Preserve in Cary, so that all could share a spot that she often went to for respite and reflection.

A letter to Barb

By Melissa Phipps

Barb Garlock was a special person in my life and greatly influenced my professional career. I would like to honor her memory by sharing a thank you note to Barb:

Dear Barb,

Thank you for all the ways that you blessed me!

Thanks for introducing me to health law. Before I met you in 1993, the summer following my second year of law school, I had not giv-

en one thought to practicing health law. Your passion for patient care issues was infectious and by the end of my internship at Petree Stockton, I knew that "when I grew up," I wanted to be just like you.

Thanks for being a great teacher and mentor. You invited me into the world of patient care and provided a solid foundation for me by teaching me all about informed consent, advance directives, patient rights, privacy of health information (you were a pioneer in this area way before HIPAA), involuntary commitment, medical staff issues, EMTALA and the physician-patient relationship. Every project you gave me was challenging, fun and rewarding. I absolutely loved working with you!

Thanks for being a great role model to me. I learned so much by watching you artfully balance a demanding law practice with your life as a wife and mother. I always knew what was most important to you and delighted in seeing Marie's latest artwork and pictures of baby Hunter. When I shared that I was pregnant with my first child, you were ecstatic! Thank you for supporting my decision to practice law part-time after Jackson was born and for the wonderful advice you gave me. Because of you, I was able to continue working remotely after we moved out of state for my husband's job. This was an amazing gift to me. When I was offered an in-house position with Novant Health in 1998, you affirmed my professional abilities and strongly encouraged me to make the transition. It has been a great fit for me and I absolutely love my job! Thank you for nudging me in the right direction and for being just as excited over the births of my second, third and fourth children!

Thanks for openly sharing your breast cancer journey. Your blog was not only a way to tell your story, but also a wonderful method of informing people about breast cancer and what it really means to undergo various forms of treatment. You allowed us an honest view from the balcony as you faced your illness with courage, determination and humor. I will always treasure our last visit several years ago when Jan Yarborough and I came to see you. As always, you were much more interested in hearing about my children and updating me on Marie and Hunter than you were in talking about yourself.

Thank you for reaching out to me in 2010 when I was diagnosed with DCIS (ductal carcinoma in situ) – the same type of breast cancer that you were diagnosed initially. Just knowing that you too had survived a mastectomy gave me comfort as I prepared for my surgery. I so appreciated your encouragement, especially when I was overcome with fear that I too would have a recurrence. You gently reminded me that your story was not my story – that just because you had a recurrence did not mean that I would also. I am now a three-year survivor and hope that whatever the future holds for me, I will be able to face it with the courage and grace that you demonstrated.

Finally, thank you for showing me how to die well. When it became clear that the end was near, you honestly shared the news on your blog that the cancer had spread and that there were no more treatments. Then, you invited all of your friends to come to a potluck dinner at your house. You mentioned that you wanted each person to look through your belongings and choose something that they wanted to have in remembrance of you. You reasoned that it would spare your family from having to decide what to do with your things and that you would prefer folks to get items that they liked and would use. I had never heard of such a thing – not then and not since. What a great way to bless your friends at the end of your life! I didn't read the blog until after the party had occurred, but wish I could have been there to tell you goodbye in person. In a world where many people stop living and then die, you were a great example of what it means to live well until the end.

I am so grateful to have been one of the many, many people you touched over the course of your life. I love you. I miss you so much. Thank you for being my friend.

Forever yours,
Melissa

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