

STATUTORY QUIXOTICS: TILTING AGAINST THE HEALTH CARE BUSINESS AMENDMENTS TO THE BANKRUPTCY CODE

INTRODUCTION

[B]ehold . . . there appears thirty or forty monstrous giants, with whom I mean to fight

What giants? [T]hose which appear there are no giants, but windmills

*They are giants . . . I enter into cruel and unequal battle with them.*¹

Ms. Smith fell outside her home injuring her leg. Her health care providers have filed for bankruptcy, affecting, to varying degrees, their ability to provide services to their patients. Ms. Smith's family decided to take her to a private care provider, Big Box Managed Care. At Big Box, Dr. Jones examined her and sent her to Exclusive Radiology, a referral-only provider of diagnostic radiology services. Exclusive performed routine X-rays on Ms. Smith. However, staffing reductions and failures to maintain its equipment, delayed Exclusive's diagnosis of the fracture in Ms. Smith's leg.

Ms. Smith returned to Dr. Jones at Big Box to have her leg cast. Due to its own staffing reductions, Big Box assigned an inexperienced orthopedic technician to apply Ms. Smith's cast. The technician misapplied the cast. Ms. Smith suffered a serious complication from a fractured femur and was admitted to Regional Health Public Hospital for surgery. Prior to her surgery, Regional's steam autoclave, which is used for sterilizing surgical instruments, malfunctioned due to poor maintenance, and this malfunction remained unnoticed until after Ms. Smith's procedure. Ms. Smith developed an infection in her leg, and it was subsequently amputated. Regional Health Hospital employed a Quality Assurance Nurse who reported the incident, under the terms of a mandatory reporting statute, to the State Department of Health and Human Services. The important question for Ms. Smith is: how will

¹ Miguel de Cervantes Saavedra, DON QUIXOTE, PART I (1605), *reprinted in* THE HARVARD CLASSICS VOL. XIV (Thomas Shelton trans., Charles W. Eliot ed., P.F. Collier & Son 1909-14), *available at* <http://bartleby.com/14/108.html>.

bankruptcy courts approach the problems she experienced in light of the recent “health care business” changes to the Bankruptcy Code (“Code”)?

The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (“BAPCPA”) made, in part, changes to how courts approach bankruptcies involving health care businesses.² The Code defines a “health care business” as a public or private entity primarily engaged in providing facilities and services for “the diagnosis or treatment of injury, deformity, or disease and surgical, drug treatment, psychiatric, or obstetric care.”³ The definition itself gives rise to interesting questions for the courts,⁴ as traditional notions of a health care business may not apply.⁵ While the Code defines the term at some length, not all businesses that deliver health care to patients fit neatly within the Code’s terms.⁶ In the Ms. Smith hypothetical, Exclusive and Big Box may not fall within BAPCPA’s health care business amendments to the Code⁷ because neither provides all of the services⁸ within the Code’s definition of a health care business. Therefore, bankruptcy courts would deny Ms. Smith the Code’s protections in the cases pending against Exclusive and Big Box. However, Regional Health Hospital would fit within the Code’s definition.⁹

Perhaps BAPCPA’s most important health care related amendment, § 333 made possible “the appointment of an ombudsman to monitor the quality of patient care and to represent the interests of the patients of the health care business.”¹⁰ The appointment requires the ombudsman to monitor the quality of patient care and to report any findings to the court.¹¹ Debate exists about what Congress intended when it sought to monitor the “quality of patient care.”¹² The provision allows courts the discretion to forego the appointment of an ombudsman only where there is a finding that the appointment “is not

² See Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, Pub. L. No. 109-8, 119 Stat. 23 (2005). Congress enacted BAPCPA on April 20, 2005. Section 1104, entitled “Appointment of Ombudsman to Act as Patient Advocate,” is codified under the title “Appointment of Patient Care Ombudsman.” 11 U.S.C.A. § 333 (West 2007).

³ 11 U.S.C.A. § 101(27A).

⁴ See discussion *infra* Part I.

⁵ See discussion *infra* Part I.

⁶ See discussion *infra* Part I.

⁷ See discussion *infra* Part I.

⁸ See § 101(27A)(A); see also discussion *infra* Part I.

⁹ See § 101(27A)(B). Section 101 explicitly lists hospitals as a “health care business.” Provided that Ms. Smith can establish a few factors, Regional Health would also meet the section’s requirements.

¹⁰ Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, Pub. L. No. 109-8, § 1104, 119 Stat. 23, 191 (2005).

¹¹ 11 U.S.C.A. § 333(b).

¹² See discussion *infra* Part II.

necessary for the protection of patients under the specific facts of the case.”¹³ However, Congress did not clearly indicate the degree of patient care hazard that triggers appointment.¹⁴ Thus, the poor, and perhaps even negligent, quality of Ms. Smith’s care may not rise to the level that would motivate a court to appoint an ombudsman.¹⁵

The patient care ombudsman provision, as well as its sister amendments,¹⁶ diametrically oppose traditional bankruptcy foci.¹⁷ Bankruptcy law traditionally seeks to convert and distribute a debtor’s assets,¹⁸ which the patient care ombudsman provision ignores.¹⁹ Nevertheless, in recent cases involving the ombudsman provision and related amendments, courts found financial strain on the debtor’s resources caused by the patient care ombudsman as a reason to decide *against* appointment.²⁰ The legislative history from the 1998 act indicates that Congress knew of the conflict between the health care business bankruptcy reform provisions and traditional bankruptcy law.²¹ With that knowledge, Congress did not mention the debtor’s financial status in the patient care ombudsman provision.²² Despite Congress’s lack of concern for the financial impact of the ombudsman, bankruptcy courts consider the debtor’s financial status in making the ombudsman appointment.²³

¹³ 11 U.S.C.A. § 333(a)(1).

¹⁴ Compare 144 CONG. REC. 5892 (1998) (statement of Sen. Grassley) (citing concerns about the fairness of the bankruptcy process to patients, declines in quality of care, and how patients are transferred from the bankrupt organization to another hospital), with 11 U.S.C.A. § 333 (providing simply that the ombudsman monitor the quality of patient care and represent the interests of patients).

¹⁵ See discussion *infra* Part II.

¹⁶ See 11 U.S.C.A. §§ 101(27A), 101(40A), 351, 503, 704.

¹⁷ See generally Jack M. Zackin, *The Intersection of Bankruptcy Law and Health Care Regulation*, METRO. CORP. COUNS., Jan. 2006, at 1, 1 (“States regulate hospitals and other health care providers to protect the health and safety of their citizens. Bankruptcy laws, on the other hand, are primarily concerned with maximizing asset values for distribution to creditors.”).

¹⁸ See *City of N.Y. v. Quanta Res. Corp. (In re Quanta Res. Corp.)*, 739 F.2d 912, 915 (3d Cir. 1984) (“The objectives of federal bankruptcy law can be broadly stated: to provide for an equitable settling of creditors’ accounts by usurping from the debtor his power to control the distribution of his assets.”).

¹⁹ See 11 U.S.C.A. § 333. The provision focuses solely on the interests of the debtor’s patients.

²⁰ See discussion *infra* Part II.

²¹ See 144 CONG. REC. 5892 (1998). Senator Grassley noted that “[u]nder current law, the bankruptcy process is oriented toward protecting the interests of creditors and helping the debtor corporation reorganize. . . . But hospitals and HMOs and nursing homes are different.” *Id.*

²² See 11 U.S.C.A. § 333. Only the provision detailing the patient care ombudsman’s duty to dispose of patient care records mentions the debtor’s financial status. Specifically, the Code recognizes that a trustee may have insufficient funds to maintain patient care records in a manner required by state or federal law. Section 351, where funds are insufficient, requires the trustee to store patient records for one year, to provide notice to patients of their need to claim the records, and to destroy unclaimed records after one year. *Id.* § 351.

²³ See discussion *infra* Part II.B.

Thus, Ms. Smith's health care providers would likely assert such an argument in opposition to an appointment of an ombudsman in their bankruptcy cases.

Congress also did not address with the BAPCPA Amendments the effect other regulatory measures should have on implementing the health care business amendments.²⁴ These measures include internal mechanisms particular to the health care industry. Many health care businesses have their own quality assurance personnel who monitor the quality of patient care.²⁵ However, courts should consider whether these persons can serve as the ombudsman.²⁶ State agencies also operate to regulate health care businesses. Courts should consider whether agencies can adequately monitor a bankrupt health care business and respond to patient issues.²⁷ Because of the existence of both state and private regulatory measures, Ms. Smith's health care providers may argue that there are sufficient protections in place for patients.

Additionally, the Code requires that the ombudsman "represent the interests of the patients."²⁸ Because neither the patients nor the ombudsman have a financial interest in the debtor, there is a question as to whether the ombudsman provision creates a right in patients "affected by the proceeding to appear and be heard."²⁹ In this situation, courts should consider the possibility that patients, and not the debtor or the trustee, are in the better position to state the facts of the businesses' quality of care and whether their interests require representation.³⁰ For Ms. Smith, intervention may allow her or her family to argue that the interests of patients are in danger.

Don Quixote's adventure of the windmills notably parallels attempts at interpreting and implementing statutes, including those of the Code. A starting point to avoid confusing giants from windmills comes from Judge Learned Hand, who "has vividly admonished us not to be caught in the trap of language which seems, literally, too broad or too narrow to accommodate the patent legislative purposes."³¹ Given Judge Hand's admonishment, the giants in a

²⁴ See discussion *infra* Part II.

²⁵ See generally *infra* notes 189–93 and accompanying text (addressing the argument that a quality assurance nurse will protect the interests of patients).

²⁶ 11 U.S.C.A. § 333(a)(2)(A); see also discussion *infra* Part II.

²⁷ See discussion *infra* Part II.

²⁸ 11 U.S.C.A. § 333.

²⁹ *In re Addison Cmty. Hosp. Auth.*, 175 B.R. 646, 650 (Bankr. D. Mich. 1994) (denying intervention by a citizens group attempting to intervene as taxpayers affected by the bankruptcy process).

³⁰ See discussion *infra* Part II.C.

³¹ *In re S.S.I.W. Corp.*, 7 B.R. 735, 743 (Bankr. S.D.N.Y. 1980) (quoting *S.E.C. v. F.O. Baroff Co. Inc.*, 497 F.2d 280, 282 (2d Cir. 1974)) (internal quotation marks omitted).

statutory provision lie in between a construction that is overly-broad and a construction that is overly narrow. Confusion occurs when a construction is reached that fails to achieve the patent legislative purpose of a statute. Unfortunately, the failure to achieve the legislative purpose behind the “Health Care Business” Amendments to the Code results from both the language of the statutes and judicial misapplication or misapprehension.

Congress promulgated the patient care ombudsman provision to protect vulnerable patients from inequities that arise during the bankruptcy process. This Comment will, first, examine how courts have narrowly construed the relevant provisions to the detriment of the amendment’s purpose. Second, the Comment will examine which factors courts consider when determining whether the ombudsman is necessary for the protection of patients under the specific facts of the case. Finally, the Comment will recommend an approach to the appointment of a patient care ombudsman that will honor Congress’s patent legislative purpose. The analysis courts employ for the patient care ombudsman’s appointment should begin with the premise that Congress intended the appointment as the default. Courts should forego the appointment only where the facts of the case ensure quality of care and protection of patient interests.

I. DEFINING “HEALTH CARE BUSINESS”

The Code’s definition of “health care business” provides the first opportunity for inequality of protection among patients. The problem lies in the use of the term “general public” to define a “health care business”.³² A health care business is one that “offer[s] to the *general public* facilities and services for” patient care.³³ A narrow construction of “general public” would undermine patient protection.³⁴ Congress could better serve patients and courts by providing a definition of “health care business” that specifically refers to patients or the class of patients Congress sought to protect.

Inequality may also occur when courts misunderstand the nature of a business.³⁵ Congress provided, in § 101(27A), qualifying factors for, and listed examples of, a “health care business.”³⁶ Courts who add factors not

³² See 11 U.S.C.A. § 101(27A) (West 2007).

³³ *Id.* (emphasis added).

³⁴ See discussion *infra* Part I.A.

³⁵ See discussion *infra* Part I.B.

³⁶ 11 U.S.C.A. § 101(27A).

specifically stated within § 101(27A), risk eliminating protections for patients of a business that would have otherwise qualified under the statute.³⁷ One court's decision helps instruct on the problems presented in defining "general public."³⁸

A. *General Public Defined*

In re 7-Hills Radiology eliminates from the Code's protection patients of health care providers who take patients by way of referral, as the vast majority of health care providers do. The case illustrates how inequality can occur from defining a "health care business" too narrowly. The *7-Hills Radiology* debtor recanted an earlier claim of being a health care business stating that: (1) it saw patients on a referral-only basis; (2) it "[did] not advise the patients" but, instead, advised physicians; and (3) the physicians, not the debtor, maintained the patient records.³⁹ The court reached the ultimate conclusion that the debtor did not meet the Code's definition of "health care business," because, by limiting itself to referral-only patients, the debtor did not meet the "general public" requirement of § 101(27A).⁴⁰ The court stated that "[no] member of the general public [could] walk in and request an X-ray or any other procedure [the debtor] perform[ed]."⁴¹

The *7-Hills Radiology* court's narrow construction of "general public" eliminates from the Code's protection a vast number of patients, including patients of businesses explicitly mentioned in the definitional provision.⁴² No member of the general public may walk into a facility and request a surgical procedure. Thus, the court's holding in *7-Hills Radiology* would eliminate surgical facilities, explicitly written in the list of examples,⁴³ from the amendment's protection. Further, the *7-Hills Radiology* court conceded that the debtor's treatment of all referrals may "constitute[] treating the general public."⁴⁴ However, the court disposed of this argument,⁴⁵ noting that other

³⁷ Cf. *In re 7-Hills Radiology, LLC*, 350 B.R. 902, 905 (Bankr. D. Nev. 2006). The court stated that Congress intended to target businesses that had ongoing contact with patients and provided them shelter and sustenance. *Id.* However, the factors the court relies upon are completely absent from 11 U.S.C.A. § 101(27A). See discussion *infra* Part I.B.

³⁸ See *In re 7-Hills Radiology*, 350 B.R. at 902.

³⁹ *Id.* at 903–04.

⁴⁰ *Id.* at 904–05.

⁴¹ *Id.* at 904.

⁴² See generally 11 U.S.C.A. § 101(27A)(B) (West 2007) (listing facilities intended as examples of health care businesses).

⁴³ *Id.* § 101(27A)(B)(i)(II).

⁴⁴ *In re 7-Hills Radiology*, 350 B.R. at 904 (internal quotation marks omitted).

federal statutes using the “offering to the general public” qualification provided no helpful insight.⁴⁶

The court for *In re Medical Associates of Pinellas, L.L.C.*,⁴⁷ experienced the same definitional difficulties posed to other courts.⁴⁸ Like *7-Hills Radiology*, the court looked to whether the debtor offered services to the general public. The debtor here provided administrative support to physicians, and the services it provided to the public were ancillary to its main function.⁴⁹ In other words, Medical Associates of Pinellas interacted primarily with physicians and not patients.⁵⁰ This nuanced analysis into the debtor’s relationship with patients avoided a result like that in *7-Hills Radiology*.

S.S.I.W. Corp. provides a better approach to the “general public” analysis.⁵¹ The court in *S.S.I.W. Corp.* contended with the definition of a “stockbroker,”⁵² which refers to interactions with the general public.⁵³ To reach its decision, the court considered whether the defendant dealt (1) in securities; (2) with customers; and (3) with members of the general public.⁵⁴ These steps provide a useful form of analysis for courts interpreting § 101 (27A), as it relates to health care businesses and their dealings with their patients.

The *S.S.I.W. Corp.* court first examined how the Code defines “securities” as used in the definition of a stockbroker.⁵⁵ Fortunately, the Code defines security in § 101.⁵⁶ Using this definition and the business dealings of the

⁴⁵ *Id.* at 904; see discussion *infra* Part I.B.

⁴⁶ *In re 7-Hills Radiology*, 350 B.R. at 904 n.4.

⁴⁷ 360 B.R. 356 (Bankr. M.D. Fla. 2007).

⁴⁸ *Id.* at 359.

⁴⁹ *Id.*

⁵⁰ The debtor in this case apparently did provide “laboratory support” that was directed at the patients, but the court found this to be a minimal part of its services. *Id.* at 360.

⁵¹ See generally *In re S.S.I.W. Corp.*, 7 B.R. 735 (Bankr. S.D.N.Y. 1980).

⁵² The court looked to 11 U.S.C. § 101(39) (now 11 U.S.C. § 101(53A) (2000)). *In re S.S.I.W. Corp.*, 7 B.R. at 736 n.5. Notably, the two definitions do not differ in any significant manner. The *S.S.I.W. Corp.* court defined stockbroker as:

A “Stockbroker” is defined in the Bankruptcy Reform Act, § 101(39), to mean a “person with respect to which there is a customer . . . engaged in the business of effecting transactions in securities “(A) for the account of others; or (B) with members of the *general public* from or for such person’s own account”

Id. Compare *id.*, with 11 U.S.C. § 101(53A) (2000) (using the same language to define stockbroker).

⁵³ *In re S.S.I.W.*, 7 B.R. at 736 n.5.

⁵⁴ *Id.* at 736–43.

⁵⁵ *Id.* at 736–37.

⁵⁶ *Id.* (citing 11 U.S.C. § 101(35) (now codified at 11 U.S.C § 101(49)).

defendant, the court concluded that S.S.I.W. dealt in securities.⁵⁷ The relevant question then becomes, if a stockbroker deals in securities, in what does a health care business deal?

The *7-Hills Radiology* debtor declared that it offered “radiological tests . . . to patients who are referred by treating physicians.”⁵⁸ The court reasoned that the target of the debtor’s services were the referring physicians.⁵⁹ The debtor presumably provided what is termed “diagnostic radiology.”⁶⁰ Notably, diagnostic services include “activities related to the diagnosis made by a physician.”⁶¹ The radiological tests, then, performed by the debtor were diagnostic services related to the diagnosis made by the referring physician.⁶² Further, Congress defined “medical and other health services” in the Social Security Act⁶³ to include diagnostic X-ray tests and the “materials and services of technicians” providing X-ray therapy.⁶⁴ Therefore, while X-ray interpretation constituted only part of the total services provided by 7-Hills Radiology, the radiant tests given to the patients were the most important.

The *S.S.I.W. Corp.* court also analyzed whether the defendant dealt in securities with “customers.”⁶⁵ The court again turned to the Code’s definition of customer.⁶⁶ A customer is someone who entrusts a stockbroker with their cash or security in a securities transaction.⁶⁷ The customers of a stockbroker are analogous to the patients of a health care business, in that each relationship presumably includes both a service and compensation component.

While § 101(27A) does not refer to patients, it does refer to providing services to the general public. Section 101(40A) declares that patients are

⁵⁷ *Id.* at 737.

⁵⁸ *In re 7-Hills Radiology, LLC*, 350 B.R. 902, 904 (Bankr. D. Nev. 2006).

⁵⁹ *Id.* at 904.

⁶⁰ See MOSBY’S MEDICAL, NURSING, & ALLIED HEALTH DICTIONARY 515 (6th ed. 2002) (defining diagnostic radiology as “medical imaging using external sources of radiation”). Radiology uses radiant energy to diagnose and treat disease. *Id.* at 1460.

⁶¹ See *id.* at 515 (defining diagnostic services).

⁶² But see *In re 7-Hills Radiology*, 350 B.R. at 904 (declaring that the debtor’s services are provided to referring physicians).

⁶³ 42 U.S.C. § 1395x(s) (2000).

⁶⁴ *Id.* §§ 1395x(s)(3), (4).

⁶⁵ *In re S.S.I.W. Corp.*, 7 B.R. 735, 737–40 (Bankr. S.D.N.Y. 1980).

⁶⁶ See *id.* at 738–40.

⁶⁷ *Id.* at 739. See also *WesBanco Bank Barnesville v. Rafoth (In re Baker & Getty Fin. Servs., Inc.)*, 106 F.3d 1255, 1260 (6th Cir. 1997) (“[I]t is the act of entrusting the cash to the debtor for the purpose of effecting securities transactions that triggers the customer status provisions.” (quoting *In re ESM Gov’t Sec., Inc.*, 812 F.2d 1374 (11th Cir. 1987))).

“individual[s] who obtain[] or receive[] services from a health care business.”⁶⁸ Medical dictionaries define a patient as “a recipient of a *health care service*” or, alternatively, a “client in a *health care service*.”⁶⁹ Thus, the “general public” that Congress intended in § 101(27A) includes the patients of the health care business.⁷⁰ The *7-Hills Radiology* court noted that, “[n]o member of the general public may walk in and request an X-ray or any other procedure [the debtor] performs.”⁷¹ While perhaps true, the court did not consider the possibility that nearly every provider of radiological services likely requires a physician’s or other licensed provider’s order before performing X-rays.⁷² Irrespective of that argument, the *7-Hills Radiology* debtor could not seriously argue that the radiologist and its interpretation are not services being provided to patients. Therefore the court, in determining whether the targets of the debtor’s services are the physicians or the patients, should consider who actually receives the services of the business.

The *S.S.I.W. Corp.* court first looked at the historical genesis of the definition of “stockbroker” and its inclusion of the term “general public.”⁷³ The court noted that the Bankruptcy Act of 1898 failed to adequately address broker bankruptcies.⁷⁴ Congress rectified the problem in 1938, but in doing so, failed to define the term “stockbroker.”⁷⁵ However, the Bankruptcy Reform Act of 1978 included a definition of stockbroker and included the phrase “general public.”⁷⁶ Thus, the court looked at earlier securities legislation⁷⁷ and

⁶⁸ 11 U.S.C.A. § 101(40A) (West 2007).

⁶⁹ MOSBY’S MEDICAL, NURSING, & ALLIED HEALTH DICTIONARY, *supra* note 60, at 1294 (emphasis added).

⁷⁰ Compare 11 U.S.C.A. § 101(27A), with 11 U.S.C.A. § 101(40A).

⁷¹ *In re 7-Hills Radiology, LLC*, 350 B.R. 902, 904 (Bankr. D. Nev. 2006).

⁷² Cf. CONN. GEN. STAT. ANN. § 20-74bb (West 2007) (allowing licensed radiographers to operate X-ray equipment under the supervision and upon the “order” of a physician); FLA. STAT. ANN. § 32-461.003 (West 2007) (defining direct supervision, for a certified podiatric X-ray assistant, to mean that the podiatric physician “orders” the X-ray and remains on the premises during the X-ray); GA. CODE ANN. § 43-34-26.3 (West 2007) (directing that nurse protocol agreements must identify the types of diagnostic tests the advanced practice nurse may order, and if a physician is delegating the authority to “order” an X-ray, the X-ray must be interpreted by a trained physician). While no specific statutory mandate can be found, compelling reasons exist for why providers require a physician’s order to receive an X-ray. For instance, the government, through the Nuclear Regulatory Agency, heavily regulates the industry. Moreover, insurance companies would likely refuse payment for non-physician ordered X-rays.

⁷³ *In re S.S.I.W. Corp.*, 7 B.R. 735, 740–43 (Bankr. S.D.N.Y. 1980). See *supra* note 51–52 and accompanying text.

⁷⁴ *In re S.S.I.W.*, 7 B.R. at 740.

⁷⁵ *Id.*

⁷⁶ *Id.* at 741.

⁷⁷ *Id.* The Securities and Exchange Commission had been advocating for a change to the stockbroker definition that would include “dealers having ‘public customers.’” *Id.*

formulated a “composite picture of ‘members of the general public’, *i.e.* inexpert, passive, relatively uninformed investors.”⁷⁸ The court supported this composite picture by looking at the Security Investor Protection Act of 1970 (“SIPA”).⁷⁹ The court noted that “SIPA’s avowed purpose [is] to protect individual investors from financial hardship.”⁸⁰ The court then concluded that “a determination as to the meaning of ‘general public’ . . . should turn on *whether a particular class of persons affected . . . needs the protection of the Act.*”⁸¹ In finding against the plaintiff, the court found that the plaintiff was a “sophisticated investor[] . . . not within the class the 1978 Act deemed to be within the ambit of [the Act’s] protection under the designation, ‘members of the *general public.*’”⁸² Courts, thus, should focus on who Congress intended to protect with the term “general public” of § 101(27A).⁸³

Two types of businesses emerge for the purposes of § 101(27A). First, a business that provides services directly for, or in furtherance of, patient care. Second, a business that offers services to health care providers who are ancillary to the delivery of patient care. Obviously, providers of direct patient care (e.g. 7-Hills Radiology) are more likely to fall within the definition of a health care business for the Code’s purpose than those who do not (Medical Associates of Pinellas). In order to avoid inequality amongst patients, courts should construe “general public” in a way that includes businesses providing direct patient care services. Unfortunately, patients’ problems do not end with this finding. A health care business should also be found to be a facility offering services to the general public.⁸⁴

⁷⁸ *Id.* at 742.

⁷⁹ *Id.* (referring to SIPA as a “fountainhead of the 1978 Bankruptcy Reform Act stockbroker provisions” and finding that SIPA was “consistent . . . with [the 1978 Act’s] statutory aims”).

⁸⁰ *Id.* at 743 (internal quotation marks and citations omitted).

⁸¹ *Id.* (internal quotation marks and citations omitted) (emphasis added).

⁸² *Id.* at 742 (citation omitted) (emphasis added).

⁸³ *See* 11 U.S.C.A §§ 333, 351, 503, 704 (West 2007).

⁸⁴ *See id.* § 101(27A). Health care businesses offer:

(A) to the general public facilities and services for—(i) the diagnosis or treatment of injury, deformity, or disease; and (ii) surgical, drug treatment, psychiatric, or obstetric care; and (B) includes—(i) any—(I) general or specialized hospital; (II) ancillary ambulatory, emergency, or surgical treatment facility; (III) hospice; (IV) home health agency; and (V) other health care institution that is similar to an entity referred to in subclause (I), (II), (III), or (IV); and (ii) any long-term care facility, including any—(I) skilled nursing facility; (II) intermediate care facility; (III) assisted living facility; (IV) home for the aged; (V) domiciliary care facility; and (VI) health care institution that is related to a facility referred to in subclause (I), (II), (III), (IV), or (V), if that institution is primarily engaged in offering room, board, laundry, or personal assistance with activities of daily living and incidentals to activities of daily living.

B. *Facilities and Services*

Courts also often misconstrue the list of facilities and services in § 101(27A), limiting patient protections.⁸⁵ For instance, in *7-Hills Radiology*, the court noted that the “debtor might argue that it is not in the business of both ‘diagnosis or treatment of injury, deformity, or disease’ and ‘surgical, drug treatment, psychiatric or obstetric care,’ as the statute would seem to require, given Congress’s use of the conjunction ‘and’ between clause (i) and clause (ii).”⁸⁶ Section 101(27A) employs “and” to connect most of the statute’s requirements, clauses, and subclauses.⁸⁷ The *7-Hills Radiology* court’s construction leads to odd results.

For example, the *Banes* court found that “the word ‘and’ . . . should generally be given its ordinary conjunctive meaning.”⁸⁸ Because of that, the court required a debtor to “meet the requirements of every subsection” to be a health care business for the purposes of the ombudsman provision.⁸⁹ However, the *Banes* court did not address the first “and” occurring within the statute.⁹⁰ In particular, § 101(27A) requires that a health care business “offer[] to the general public *facilities and services* for” the activities listed in (A)(i) and (A)(ii).⁹¹ Using the court’s “conjunctive and” test,⁹² an anomaly within the statute occurs with “home health agency.”⁹³ The National Center for Health Statistics, a division of the Centers for Disease Control and Prevention, defines “home health care” as “care provided to individuals and families *in their place of residence*.”⁹⁴ Thus, a “home health agency” offers no facilities to the general public,⁹⁵ but instead utilizes the patient’s own facilities for the delivery of its services. However, Congress included home health agencies in its list of

Id.

⁸⁵ See generally *In re 7-Hills Radiology, LLC*, 350 B.R. 902, 904–05 (Bankr. D. Nev. 2006); *In re Banes*, 355 B.R. 532 (Bankr. M.D.N.C. 2006).

⁸⁶ *In re 7-Hills Radiology*, 350 B.R. at 905 (quoting 11 U.S.C. § 101(27A)(A)(i)–(ii)) (emphasis removed).

⁸⁷ See 11 U.S.C.A. § 101(27A).

⁸⁸ *In re Banes*, 355 B.R. at 534.

⁸⁹ *Id.*

⁹⁰ See *id.* at 532.

⁹¹ 11 U.S.C.A. § 101(27A).

⁹² See generally *In re Banes*, 355 B.R. at 534.

⁹³ 11 U.S.C.A. § 101(27A)(B)(i)(IV).

⁹⁴ National Center for Health Statistics, NCHS Definitions—Home Health Care, <http://www.cdc.gov/nchs/data/nchsdefs/homehealthcare.htm> (last visited Jan. 12, 2008) (emphasis added).

⁹⁵ See MOSBY’S MEDICAL, NURSING, & ALLIED HEALTH DICTIONARY, *supra* note 60, at 823 (defining “home health agency” as a provider of in-home care).

example health care businesses despite the fact that these businesses did not provide both facilities and services to the general public.⁹⁶

A second anomaly occurs with “assisted living facility,”⁹⁷ but this anomaly must be considered in light of the catch-all subclause (VI) of § 101(27A)(B)(ii).⁹⁸ First, while they do provide facilities to the general public,⁹⁹ assisted living facilities do not provide services for “the diagnosis or treatment of injury, deformity, or disease [] and surgical, drug treatment, psychiatric, or obstetric care.”¹⁰⁰ One may conclude from this, then, that Congress did not intend those subclauses to restrict the interpretation of “health care business.” However, courts should consider this proposition in light of subsection (B)(ii)(VI).¹⁰¹ That subclause contains its own list of services that the institution must provide which does not include those of services listed in (A)(i) or (ii).¹⁰² Subsection (B)(ii)(VI) lists as its exemplary facility any “health care institution . . . related to a facility referred to in” subclauses (B)(ii) (I) through (V).¹⁰³ A court may read this qualifier to mean that the facility must be jointly owned by an entity providing services in a facility falling into the definition of “skilled nursing facility; intermediate care facility; assisted living facility; home for the aged; [or] domiciliary care facility” in the preceding subclauses.¹⁰⁴ Adding to the confusion, subsection (B)(ii)(VI) lists services that are identical to those services traditionally offered in assisted living facilities.¹⁰⁵ Therefore, subsection (B)(ii)(VI) and its qualifier provide no resolution to the problem created by the failure of assisted living facilities to

⁹⁶ See generally 11 U.S.C.A. § 101(27A).

⁹⁷ *Id.* § 101(27A)(B)(ii)(IV).

⁹⁸ *Id.* § 101(27A)(B)(ii)(VI). This section includes in the list of example health care businesses, any “health care institution that is related to a facility referred to in subclause [(B)(ii)] (I), (II), (III), (IV), or (V), if that institution is primarily engaged in offering room, board, laundry, or personal assistance with activities of daily living and incidentals to activities of daily living.” *Id.*

⁹⁹ National Center for Health Statistics, NCHS Definitions—Assisted Living Residences, <http://www.cdc.gov/nchs/dataawh/nchsdefs/assistedlivingresidences.htm> (last visited on Jan. 12, 2008) (“Assisted living residences provide some assistance with activities of daily living and instrumental activities of daily living but do not provide round-the-clock skilled nursing services. Assisted living facilities and in-home assisted living care stress independence and generally provide less intensive care than that delivered in nursing homes and other long-term care institutions, but there is no standard definition of these places as they are licensed by individual States, if at all.”).

¹⁰⁰ 11 U.S.C.A. § 101(27A)(A)(i)–(ii).

¹⁰¹ *Id.* § 101(27A)(B)(ii)(VI).

¹⁰² *Id.*

¹⁰³ *Id.* (emphasis added).

¹⁰⁴ *Id.* § 101(27A)(B)(ii).

¹⁰⁵ National Center for Health Statistics, *supra* note 99.

provide “diagnosis or treatment of injury, deformity, or disease; and surgical, drug treatment, psychiatric, or obstetric care.”¹⁰⁶

While the *Banes* court did not address the first “and” occurring in § 101(27A), the court did address the second occurrence of the word.¹⁰⁷ The court concluded that businesses must be engaged in activities contained in both subclauses of § 101(27A)(A) to be considered a “health care business.”¹⁰⁸ Again, however, some centers that fall into the list of facilities in § 101(27A)(B) will not provide services contained in both subclauses. For example, independent birthing centers do not provide for the diagnosis or treatment of injury, disease, or deformity but do provide obstetric care.¹⁰⁹ The *Banes* court did not note that the services listed in (A)(i) are general services inherent to virtually all health care providers, with some previously-noted exceptions, while those listed in (A)(ii) are specific to only certain providers of health care.¹¹⁰

Finally, the *Banes* court reasoned that the list of facilities contained in subsection (B) describes facilities that “involved ‘direct and ongoing contact with patients’ that provided patients with ‘shelter and sustenance in addition to medical treatment.’”¹¹¹ The court noted that while “includes,” leading the list in subsection (B), creates a statutorily-constructed non-exclusive list,¹¹² “the types of business listed *are all* of such a similar nature in that they provide both housing and treatment . . . that it is difficult to imagine that [Congress] . . . intended” a business not possessing those same qualities to fall within the definition.¹¹³ However, the court’s reasoning fails on two accounts. First, ancillary ambulatory, emergency, and surgical treatment facilities¹¹⁴ do not provide their patients with ongoing contact. Those facilities fall generally under the definition of “ambulatory care,” which is care that does not require

¹⁰⁶ 11 U.S.C.A. § 101(27A)(A)(i)–(ii).

¹⁰⁷ *In re Banes*, 355 B.R. 532, 534–35 (Bankr. M.D.N.C. 2006).

¹⁰⁸ *Id.*; see also *In re 7-Hills Radiology, LLC*, 350 B.R. 902, 905 (Bankr. D. Nev. 2006).

¹⁰⁹ Marion McCartney, *Birth Center FAQ’s: How Are Birth Centers Different? A Birth Center Provider Explains*, <http://www.birthcenters.org/birth-center-faq/bc-difference.php> (last visited Jan. 12, 2008). “Birth centers were designed for healthy, low risk mothers and healthy babies.” *Id.* Mothers and babies experiencing problems are transferred to a hospital for care. *Id.*

¹¹⁰ Compare 11 U.S.C.A. § 101(27A)(A)(i) (listing services for treating or diagnosing injury, deformity, or disease), with § 101(27A)(A)(ii) (listing services for surgical, drug treatment, psychiatric, or obstetric care).

¹¹¹ *In re Banes*, 355 B.R. at 535 (quoting *In re 7-Hills Radiology*, 350 B.R. at 904).

¹¹² *Id.* See also 11 U.S.C. § 102 (2000) (“In this title—(3) ‘includes’ . . . [is] not limiting.”).

¹¹³ *In re Banes*, 355 B.R. at 535 (citing *In re 7-Hills Radiology*, 350 B.R. at 904–05).

¹¹⁴ 11 U.S.C.A. § 101(27A)(B)(i)(II).

admission to a health facility.¹¹⁵ Second, the facilities falling under the general umbrella of ambulatory care, along with home health agencies for reasons previously stated,¹¹⁶ do not provide their patients with “housing and sustenance” as defined by the *Banes* court.¹¹⁷ The *Pinellas* court also concluded that “the definition could include walk-in clinics where patients stay for short durations.”¹¹⁸ Though, the court stated that the definition was probably not intended to include physicians’ offices and, specifically, did not include administrative facilities.¹¹⁹

Because it serves as the trigger for all the subsequent health care related statutes, § 101(27A) provides the source for the first court decisions related to BAPCPA’s health care business amendments. Those adhering to Judge Hand’s admonishment of interpreting neither over-broadly nor too narrowly avoid the absurd results other interpretations might produce. To avoid absurd results, courts should, first, construe “general public” to be synonymous with “patients” seeking direct care services. Second, courts should not, in assessing the nature of their debtor, misconstrue the nature of the facilities and services listed in § 101(27A). Such a reading of § 101(27A) avoids eliminating patients unnecessarily from the ombudsman’s protection.

But, having established that a business meets the definitional requirements of a health care business, courts must next decide if the facts of the case establish the need for a patient care ombudsman.

II. ESTABLISHING THE NEED FOR ENGAGING THE CODE’S PROTECTION

The patient care ombudsman provides patients with their most important protection under BAPCPA’s health care business amendments.¹²⁰ Congress first considered the appointment of a patient care ombudsman under the Business Bankruptcy Reform Act of 1998.¹²¹ Congress finally implemented

¹¹⁵ National Center for Health Statistics, NCHS Definitions—Ambulatory Care, <http://www.cdc.gov/nchs/data/nchsdefs/ambulatorycare.htm> (last visited Jan. 12, 2008).

¹¹⁶ See *supra* notes 93–96 and accompanying text.

¹¹⁷ Cf. *In re Banes*, 355 B.R. at 535. The court, by using “ongoing,” implies that sustenance and shelter occur over a protracted or regular, not transient, period. Thus, one can only conclude that ambulatory care would not fit the court’s definitional requirements.

¹¹⁸ See *In re Med. Assocs. of Pinellas*, 360 B.R. 356, 361 (Bankr. M.D. Fla. 2007).

¹¹⁹ *Id.*

¹²⁰ 11 U.S.C.A. § 333(a)(1) (West 2007).

¹²¹ See Nancy A. Peterman & Sherri Morissette, *The New Health Care Bankruptcy Laws—Will Patients be Heard*, in NORTON ANNUAL SURVEY OF BANKRUPTCY LAW Pt. I §7 (Sept. 2006). See also 144 CONG. REC.

the provision in its 2005 BAPCPA amendments.¹²² The Code requires courts to appoint an ombudsman if a health care business files for bankruptcy under chapters 7, 9, or 11,¹²³ effectively creating the presumption of appointment.¹²⁴ The statute's "shall . . . unless" construction supports this finding.¹²⁵ The contention of presumption finds further support from the Interim Federal Rules of Bankruptcy Procedure,¹²⁶ which mimics the statute's "shall . . . unless" pattern.¹²⁷ However, on motion of the United States trustee or a party in interest, the court can find the appointment unnecessary.¹²⁸

The statute requires the ombudsman to perform two central functions.¹²⁹ First, the ombudsman must "monitor the quality of patient care."¹³⁰ In doing this, the ombudsman must file reports with the court "not later than 60 days after the date of appointment, and not less frequently than at 60-day intervals thereafter" but only "after notice to the parties in interest" of the filing.¹³¹ However, "if [the] ombudsman determines that the quality of patient care

5892–93 (1998) (statement of Sen. Grassley). Senator Grassley introduced the legislation that led to § 333 out of a concern for the vulnerability of patients. *Id.* He sought to ensure that the bankruptcy process was fair to patients and to ensure that hospitals, HMOs, and nursing homes maintained quality of care. *Id.*

¹²² See Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, Pub. L. No. 109-8, § 1104, 119 Stat. 23, 191 (2005) (codified at 11 U.S.C.A. § 333).

¹²³ 11 U.S.C.A. § 333(a)(1).

¹²⁴ See *id.* This section provides that:

The court *shall* order . . . the appointment of an ombudsman to monitor the quality of patient care and to represent the interests of the patients . . . *unless* the court finds that the appointment . . . is not necessary for the protection of patients under the specific facts of the case.

Id. (emphasis added); *Alabama v. Bozeman*, 533 U.S. 146, 153 (2001) ("The word shall is ordinarily the language of command." (internal quotation marks omitted) (quoting *Anderson v. Yungkau*, 329 U.S. 482, 485 (1947))). See also 82 C.J.S. *Statutes* § 368 (2007) ("The word 'shall' . . . ordinarily is imperative That is, in the absence of a showing of a contrary intent . . . the word shall is considered mandatory.").

¹²⁵ 82 C.J.S. *Statutes* § 364 (2007) ("Where an affirmative direction is followed by a negative or limiting provision, the affirmative direction becomes mandatory.").

¹²⁶ Signed on April 20, 2005, the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 went into effect on October 17, 2005. Given the obvious time constraints for promulgating new rules to cover the Act, the Advisory Committee on Bankruptcy Rules and the Committee on Rules of Practice and Procedure have urged courts to adopt the interim rules. The interim rules cover cases occurring after October 17, 2005 and are available for review on the federal judiciary's website. The Federal Judiciary, Interim Rules and Official Forms Implementing the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, <http://www.uscourts.gov/rules/interim.html> (last visited Jan. 12, 2008).

¹²⁷ 2 WILLIAM L. NORTON, JR. & WILLIAM L. NORTON, III *NORTON BANKRUPTCY LAW & PRACTICE* 2D § 169 (2006). Rule 2007.2(a) provides that "the court shall order the appointment . . . unless the court . . . finds that the appointment . . . is not necessary." *Id.*

¹²⁸ *Id.* See also 11 U.S.C.A. § 333 (a)(1).

¹²⁹ See generally 11 U.S.C.A. § 333.

¹³⁰ *Id.* § 333(a)(1).

¹³¹ *Id.* § 333(b)(2).

provided to patients of the debtor is declining significantly or is otherwise being materially compromised, [the ombudsman shall] file with the court a motion or a written report.”¹³² The ombudsman must also post notice of the report within the subject facility “in a place where it will be seen by patients and their families or others visiting the patient.”¹³³ Further, the ombudsman may not review patient records without first obtaining court approval.¹³⁴

Second, the ombudsman must “represent the interests of the patients.”¹³⁵ The ombudsman’s task to “monitor the quality of patient care”¹³⁶ seems straightforward in purpose. However, given the traditional focus of bankruptcy law, the requirement that the ombudsman “represent the interests of the patients”¹³⁷ is less clear. Here, courts confuse windmills for giants when they begin to consider factors not related to patient care or not intended by Congress to apply. For example, Ms. Smith’s health care providers each suffered from financial difficulties that affected their ability to deliver care. How should that factor into the court’s decision to appoint an ombudsman? Does the fact that Regional Health Hospital employed a quality assurance nurse affect the outcome? Does state or federal regulation have any bearing on the court’s decision? Perhaps the most important question is, how inadequate must the patient care be for the appointment of an ombudsman to be necessary?

A. *Arguments For and Against the Patient Care Provision from the Literature*

Because no court decisions have yet addressed the issue, a review of the literature assists in establishing a standard by which courts can review a debtor’s quality of patient care. Some authors argue that only extreme conditions require the appointment of an ombudsman. For example, the authors of one article assert, “[p]atient care already is a priority consideration for the bankruptcy judge, creditors’ committee, lenders, the U.S. Trustee and the debtor.”¹³⁸ However, this presumes that courts, creditors, lenders, or the U.S. Trustee possess expertise in health care or, more importantly, patient care,

¹³² *Id.* § 333(b)(3).

¹³³ 2 NORTON, *supra* note 127, at 196 (advisory committee note).

¹³⁴ 11 U.S.C.A. § 333(c)(1).

¹³⁵ *Id.* § 333(a)(1).

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ Timothy M. Lupinacci & Eric L. Pruitt, *New Player at the Health Care Reorganization Table: Practical Implications of the Patient Care Ombudsman*, AM. BANKR. INST. J., July–Aug. 2005, at 55, 56.

which arguably may not be the case.¹³⁹ Still other commentators see the ombudsman in a more threatening light.¹⁴⁰ One writes, “one can imagine potential conflicts if an aggressive ombudsman complains of staff reductions or other efforts at operating improvements which impact patient care, without rising to life-threatening levels.”¹⁴¹

While conflict may occur between ombudsman and interested parties, observers should realize that Congress did not appear to share the view that the ombudsman should react only to cases of life-threatening declines in patient care.¹⁴² Of important note, the type of case reflective of the patient care deficiencies on which Congress focused does not decry such a high-risk standard.¹⁴³ Moreover, Senator Grassley, the sponsor of the amendment,

¹³⁹ See *In re United Healthcare Sys., Inc.*, No. 97-1159, 1997 WL 176574, at *7 (Bankr. D.N.J. Mar. 26, 1997) (“Courts are not experts in public health and safety issues.”). *Accord* Response of United States Trustee, *In re Moshannon Valley Citizens, Inc.*, No. 1-06-bk-00095 (Bankr. M.D. Pa. Feb. 16, 2006), 2006 WL 1201654. The U.S. Trustee noted, “[t]he assessment required by [the appointment of the ombudsman] . . . is a difficult one and one which may require specialized expertise in the health care field.” *Id.* The U.S. Trustee further argued that where the debtor, in his opinion, failed to establish the appointment as unnecessary, the court should “adhere to the statutory directive and order the appointment of an ombudsman *who may properly assess the facts of [the] case.*” *Id.* (emphasis added). *Cf.* *Sterling Healthcare, Inc. v. Am. Int’l Specialty Lines Ins. Co. (In re Baltimore Emergency Servs. II, LLC)*, 334 B.R. 164, 168 (Bankr. D. Md. 2005). The court noted that:

If administration of the . . . malpractice claims against Debtors continues *status quo*, many claims will be paid in full and many will get nothing, although they are all in the same class. *Such an inequitable result was not contemplated by the confirmed plan*, which had been found to comply with 11 U.S.C. §1123(a)(4).

Id. at 167 (emphasis added). The court later noted the reorganization plan’s provision for dealing with medical malpractice claims stemmed from, among other things, faulty assumptions and lack of clarity. *Id.* at 171. Unfortunately, the court held that it lacked the jurisdiction to rewrite the reorganization plan, but it did have the jurisdiction to interpret, clarify, and fill in the gaps of the plan. *Id.*

¹⁴⁰ See, e.g., James C. Dechene & Shalom L. Kohn, *Health Care Issues Arising in Bankruptcy*, 3 HEALTH L. PRAC. GUIDE § 30:15 (2007).

¹⁴¹ *Id.*

¹⁴² See generally *supra* note 14 (citing concerns including the fairness of the bankruptcy process to patients, declines in quality of care, and how patients are transferred from the bankrupt organization to another hospital).

¹⁴³ See 151 CONG. REC. S1857 (daily ed. Mar. 1, 2005) (statement of Sen. Grassley). Senator Grassley stated:

At a hearing I held on nursing home bankruptcies, I learned about a situation in California where a bankruptcy trustee just showed up at a nursing home on a Friday evening and evicted the residents of that nursing home. The bankruptcy trustee didn’t provide any notice whatsoever that this was going to happen. There was absolutely no chance for the nursing home residents to be relocated. The bankruptcy trustee literally put these elderly people out on the street and changed the locks on the doors so that they couldn’t get back into the nursing home. The bankruptcy bill

stated, in support of the 1998 amendments, “[i]f the ombudsman determines that the quality of patient care is declining, he must notify the bankruptcy court so that corrective action can be taken.”¹⁴⁴ Therefore, while the appointment of an ombudsman requires some standard for assessing patient care needs, it is not clear that Congress envisioned a standard of gross deficiency. Courts must, keeping in mind their lack of expertise, seek other resources by which they may adjudge the debtor’s quality of patient care.

B. Arguments For and Against the Appointment of an Ombudsman from Case Law

In re Moshannon Valley illustrates the types of arguments presented to courts both in support of and in opposition to the ombudsman’s appointment.¹⁴⁵ The debtor in the case wrote to the court in response to a motion arguing that the ombudsman should not be appointed.¹⁴⁶ The debtor contended that “the expense of a patient care ombudsman would present an untenable financial strain for the already struggling hospital.”¹⁴⁷ The *Banes* court also relied on the debtor’s financial condition to defeat the appointment of the ombudsman.¹⁴⁸ The court noted the Code’s compensation provision and its bearing on the ombudsman appointment, and concluded that the estate would be unable to bear such costs.¹⁴⁹ The *Pinellas* court took the analysis further stating that not only the expense of the ombudsman but “the employment and compensation of professionals to assist the ombudsman, and

will prevent this from ever happening again. These are protections that we will be giving these deserving senior citizens for the first time.

Id.

¹⁴⁴ 144 CONG. REC. S3129 (daily ed. Apr. 2, 1998) (statement of Sen. Grassley).

¹⁴⁵ Response of the Debtor, *In re Moshannon Valley Citizens, Inc.*, No. 06-00095 (Bankr. M.D. Pa. Feb. 14, 2006), 2006 WL 1201653.

¹⁴⁶ *Id.*

¹⁴⁷ *Id.* at 3. In its response, the debtor acknowledged that it was a hospital, but the debtor continues by noting that it serves relatively few patients, about twelve per day. *Id.* The debtor further argued “[a]lthough . . . essential to the community it serves, the [h]ospital does not have a large number of extended stay patients. Predominately the services being provided are . . . out-patient.” *Id.* This argument appears to mimic one discussed earlier that the definition of “health care business” should be limited to entities housing patients for extended periods. See *supra* Part II.A (on the definition of a health care business). See also Lupinacci & Pruitt, *supra* note 138, at 56 (“[T]he patient care ombudsman may add unnecessary cost, expense and bureaucracy.”).

¹⁴⁸ *In re Banes*, 355 B.R. 532, 536 (Bankr. M.D.N.C. 2006) (“[T]he Debtor’s estate has no assets with which to pay an ombudsman.”).

¹⁴⁹ *Id.*

the preparation of a report with respect to the quality of patient care would serve little purpose under the circumstances of the case.”¹⁵⁰

The United States Trustee in *Moshannon Valley* responded to the financial concerns of the debtor by pointing out that “neither the Bankruptcy Code nor the Rules identify the cost of an appointment as . . . a criteria for consideration.”¹⁵¹ In addition to the language of the ombudsman provision, the Code’s section on compensation of officers addresses the ombudsman both directly and indirectly.¹⁵² In doing so, the Code allows for “reasonable compensation for actual, necessary services rendered.”¹⁵³ More important, the Code allows the court to reduce the compensation requested.¹⁵⁴ The compensation provision at issue enumerates factors relevant to the determination of reasonable compensation, but, interestingly, this part of the provision specifically leaves out the ombudsman.¹⁵⁵ Presumably, though, courts would find the factors relevant in evaluating the ombudsman’s compensation.

While these decisions do not directly analyze the degree of distress required to overcome the ombudsman appointment,¹⁵⁶ several decisions dealing with other bankruptcy appointments do provide some helpful analysis. In addressing the appointment of a trustee, one court stated that “[t]he expense . . . should not be thrust upon a struggling corporation where there has been an insufficient showing that either present management is incompetent or guilty of gross mismanagement, or that such an appointment is in the interest of creditors and other interests of the estate.”¹⁵⁷ A second court echoed this same sentiment by finding that, absent need, the financial burden of a trustee

¹⁵⁰ *In re Med. Assocs. of Pinellas, L.L.C.*, 360 B.R. 356, 362 (Bankr. M.D. Fla. 2007).

¹⁵¹ Response of United States Trustee, *supra* note 139, at 4. The Trustee also argued that, because the debtor had not filed its financial statements with the court, it was unable to assess how the appointment would affect the financial status of the organization. *Id.*

¹⁵² 11 U.S.C.A. § 330 (West 2007).

¹⁵³ *Id.* § 330(a)(1)(A). The Code also provides for reimbursement of actual, necessary expenses. *Id.* § 330(a)(1)(B).

¹⁵⁴ *Id.* § 330(a)(2) (“The court may, on its own motion or on the motion of the United States Trustee, the United States Trustee for the District or Region, the trustee for the estate, or any other party in interest, award compensation that is less than the amount of compensation that is requested.”).

¹⁵⁵ *Id.* § 330(a)(3). *But see* Lupinacci & Pruitt, *supra* note 138, at 56. The authors argue that similar reasonableness standards should be applied to the ombudsman because, “[o]therwise, the court will have little ability to manage an overactive patient care ombudsman.” *Id.*

¹⁵⁶ *See, e.g., In re Banas*, 355 B.R. 532 (Bankr. M.D.N.C. 2006); *In re Med. Assocs. of Pinellas, L.L.C.*, 360 B.R. 356 (Bankr. M.D. Fla. 2007) (stating that the debtor’s assets are insufficient but not delineating what degree of financial stress they considered to be too great).

¹⁵⁷ *In re BAJ Corp.*, 42 B.R. 595, 598 (Bankr. D. Conn. 1984).

appointment could adversely effect reorganization of the debtor.¹⁵⁸ Still other courts suggest that some type of cost/benefit analysis is appropriate in determining appointments.¹⁵⁹ As the *Pinellas* court alluded to, these same analyses appear appropriate for the appointment of the ombudsman.¹⁶⁰ Worthy of note, though, the ombudsman quite likely will cost the estate less than a trustee.

Another valid financial concern raised is whether “[t]he ombudsman will require legal counsel, particularly with regard to fulfilling his or her legal obligations under the Code.”¹⁶¹ The Code does not directly address this, so it is unclear whether courts would readily allow such an expense.¹⁶² The *Pinellas* court addressed the compensation of professionals to help the ombudsman in its decision, and the compensation of counsel may have been one of its concerns.¹⁶³ However, the need for legal counsel does not clearly arise under the ombudsman’s role as patient care monitor. When a decline in patient care occurs, the Code only requires that the ombudsman file a motion or written report with the court and provide notice to the parties in interest.¹⁶⁴ The ombudsman may require counsel, however, if called upon to perform the broader task of representing patient interests.¹⁶⁵ However, the patients would likely secure their own counsel, either individually or as a class, if such a need arose.

Courts, in arguing the debtor’s financial distress as a reason to forego the ombudsman’s appointment, fail to address three key points. First, trustees have argued correctly that § 333 does not refer to the financial state of the debtor as a factor in appointing the ombudsman.¹⁶⁶ Section 333 states only

¹⁵⁸ *In re Macon Prestressed Concrete Co.*, 61 B.R. 432, 439 (Bankr. M.D. Ga. 1986).

¹⁵⁹ *In re William A. Smith Constr. Co.*, 77 B.R. 124, 126 (Bankr. N.D. Ohio 1987). The court stated:

This appointive power of the court is to be exercised only where the protection afforded by a trustee is needed and the costs and expenses of a trustee would not be disproportionately higher than the value of the protection afforded. This test is not suggestive of a strict cost/benefit analysis, but rather, requires the Court to be mindful of any additional costs or expenses to the estate which could result from the appointment of a trustee.

Id. (citation omitted).

¹⁶⁰ *In re Med. Assocs.*, 360 B.R. at 362.

¹⁶¹ *Lupinacci & Pruitt*, *supra* note 138, at 56.

¹⁶² *See generally* 11 U.S.C.A. § 327 (West 2007) (addressing the employment of a professional person by the trustee).

¹⁶³ *In re Med. Assocs.*, 360 B.R. at 362.

¹⁶⁴ 11 U.S.C.A. § 333(b)(3).

¹⁶⁵ *Id.* § 333(a)(1).

¹⁶⁶ Response of United States Trustee, *supra* note 139, at 16.

that the court may exercise discretion if the “appointment of such ombudsman *is not necessary for the protection of patients* under the specific facts of the case.”¹⁶⁷ Congress, with full knowledge of the Code’s financial focus, chose not to use a term of dispensability such as “feasible,” “practicable,” or “where possible,” but instead chose the term “necessary” to emphasize the ombudsman’s indispensability.¹⁶⁸ Second, the Code provides courts with significant controls over the compensation of the ombudsman.¹⁶⁹ Finally, courts should note that it is the debtor with the least resources who presents the greatest danger to the patients.

A second argument revealed by *Moshannon Valley* bases itself in the theory that state regulation and licensing requirements provide sufficient oversight to mitigate the need for the ombudsman.¹⁷⁰ In support of this argument, the debtor attached copies of the State’s inspection reports.¹⁷¹ The trustee in *Moshannon Valley* argued that the possibility for rapidly changing financial conditions inherent to bankruptcy negate the logic of the “existing oversight” theory.¹⁷² In response to the trustee, commentators argue that regulatory agencies already consider the financial status of hospitals in their routine evaluations.¹⁷³ Notably, Pennsylvania, the state where *Moshannon Valley* is located, requires hospitals and ambulatory service facilities to submit annual and quarterly financial statements, which must include their assets and liabilities and any changes in financial status, to the Department of Health.¹⁷⁴

In *In re Total Woman Healthcare Center, P.C.*,¹⁷⁵ the court, in dealing with the ombudsman appointment, found that “[if] a patient has a complaint with [the quality of patient care], the patient can file a complaint with the state medical board.”¹⁷⁶ While state or federal oversight may provide courts with some degree of comfort, they should not rely too heavily upon state agencies if courts want direct or timely oversight. For example, the Composite State Board of Medical Examiners for Georgia takes sixty days just to notify patients

¹⁶⁷ 11 U.S.C.A. § 333(a)(1) (emphasis added).

¹⁶⁸ *Cf. id.* (does not reference the debtor’s financial condition in requiring the ombudsman’s appointment).

¹⁶⁹ *See* 11 U.S.C.A. § 330 (West 2007).

¹⁷⁰ Response of the Debtor, *supra* note 145, at 3 (“As part of [Pennsylvania’s] licensing procedure, the Hospital is subject to stringent guidelines, strict oversight and frequent inspections, both announced and unannounced.”).

¹⁷¹ *Id.* (including reports from the last two years of inspections).

¹⁷² *See* Response of United States Trustee, *supra* note 139, at 15.

¹⁷³ *See* Lupinacci & Pruitt, *supra* note 137, at 56–57.

¹⁷⁴ 28 P.A. CODE § 912.61–62 (1999).

¹⁷⁵ No. 06-52000 RFH, 2006 WL 3708164 (Bankr. M.D. Ga. Dec. 14, 2006).

¹⁷⁶ *Id.* at *2.

whether their complaint has been referred for an investigation.¹⁷⁷ Furthermore, the Georgia Medical Examiners Board does not release the findings of its investigation except for its own hearings.¹⁷⁸

The *Moshannon Valley* debtor inferred that state or federal regulators would oversee debtors through their regular regulatory procedures.¹⁷⁹ While the ombudsman's oversight would occur on a regular basis, in Pennsylvania, the state-announced regulatory visits occur only biennially.¹⁸⁰ Of more concern in Pennsylvania, the state precedes its announced visits with "reasonable notice . . . of its intent to conduct the site visit."¹⁸¹ Further, the state conducts unannounced surveys only where it "has received [a] complaint or has other reasonable grounds to believe that a deficiency exists."¹⁸² The Joint Commission on Accreditation of Health Care Organizations ("JCAHO") also conducts unannounced surveys but does so as its regular inspection method.¹⁸³ While submission to JCAHO survey is voluntary, JCAHO possesses considerable authority,¹⁸⁴ and, according to one senator, "Congress expects JCAHO to be a consumer watchdog on behalf of patients."¹⁸⁵ However recent failures on the part of the JCAHO led that same senator to state, "it looks like [JCAHO] is a lap dog."¹⁸⁶

Courts should also consider that agency oversight presents, at best, a doubled-edge sword. While agencies would monitor the quality of a debtor's

¹⁷⁷ GA. COMP. R. & REGS. 360-27-.03 (2002).

¹⁷⁸ GA. CODE ANN. § 43-34-37(d) (West 2007).

The results of any investigations whatsoever shall be reported only to the board, and the records of such investigations shall be kept by the board; no part of any such record shall be released for any purpose other than a hearing before the board and as provided in Chapter 34A of this title; nor shall such records be subject to subpoena.

Id.

¹⁷⁹ See generally Response of the Debtor, *supra* note 145 (referring to the regulatory processes it was subject to in the Pennsylvania such as licensing, strict oversight and frequent inspections).

¹⁸⁰ 28 PA. CODE § 101.61 (1998).

¹⁸¹ *Id.* § 101.65.

¹⁸² *Id.* § 101.81.

¹⁸³ Joint Commission on Accreditation of Health Care Organizations, Unannounced Survey Process, http://www.jointcommission.org/AccreditationPrograms/Hospitals/AccreditationProcess/Unannounced_Survey_Process.htm (last visited Oct. 11, 2007).

¹⁸⁴ *JCAHO Failed To Identify Many Deficiencies in Hospital Inspections*, GAO Report Finds, KAISER DAILY HEALTH POLICY REPORT, July 21, 2004, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=24878. (last visited Jan. 12, 2008) ("Under current law, hospitals accredited by JCAHO are automatically considered eligible for Medicare reimbursements.").

¹⁸⁵ *Id.*

¹⁸⁶ *Id.*

patient care, they can pull or severely restrict state or federal funding of a debtor found in violation of agency rules.¹⁸⁷ A debtor's loss of state or federal funding would be detrimental to patient care. Further complicating financial matters, the provisions of BAPCPA allow the Secretary of Health and Human Services to exclude a debtor from participating in Medicare or other federal health care programs, unrestricted by the automatic stay.¹⁸⁸ While it is unclear whether the Secretary will actually exclude a provider for patient care deficiencies,¹⁸⁹ the provision would provide the Secretary a powerful advantage if a postpetition audit discovered declining patient care conditions. Agency employment of payment and licensing leverage against noncompliant, financially-troubled hospitals has occurred.¹⁹⁰ However, agency employment of these strong-arm tactics shows that concern exists at the federal and state level over patient care in financially-troubled health care facilities.¹⁹¹

A final argument raised by the debtor in *Moshannon Valley* asserted that the ombudsman would provide duplicative services.¹⁹² The debtor employed a registered nurse in the position of Patient Safety Officer, Compliance Officer, and Quality Improvement/Risk Manager.¹⁹³ The respondent noted that the nurse functioned as an "independent patient care representative."¹⁹⁴ The

¹⁸⁷ See *Riverside Calif., Hospital Fires CEO as Financial Troubles Mount*, THE BUS. PRESS, June 3, 2002 ("[The Hospital] was crippled earlier this year when federal and state inspectors briefly dropped [it] from the Medicare and Medi-Cal . . . programs. . . . Inspectors said . . . patient safety was in jeopardy.")

¹⁸⁸ 11 U.S.C.A. § 362(b)(28) (West 2007).

¹⁸⁹ See generally Peterman & Morissette, *supra* note 121, at 170 ("Traditionally, Medicare simply offset any overpayments to amounts owed by the business. . . . This section is very broad and may be used to exclude a debtor . . . if . . . the debtor owes money . . . due to prepetition overpayments.")

¹⁹⁰ See John Dorschner, *South Beach Facility Shuts Down*, MIAMI HERALD, Mar. 2, 2006, at 1C. South Beach Community Hospital filed for bankruptcy after the Florida Agency for Health Care Administration filed an emergency order for an immediate moratorium on any new patients. *Id.* The author notes, "[in] recent months, the hospital has been struggling to comply with orders from state regulators and federal officials, who threatened to stop Medicare payments, a virtual death knell for any Florida hospital." *Id.* at 6C (emphasis added). See also *Riverside Calif., Hospital Fires CEO as Financial Troubles Mount*, *supra* note 187.

¹⁹¹ See Dorschner, *supra* note 190. In filing its emergency order, The Florida Agency for Health Care Administration, according to the author, cited "conditions in the facility present[ed] an immediate or direct threat to the health, safety, or welfare of the residents." *Id.* at C, 6C. The author went on to note that, the agency issued the order over fears that the hospital would "re-open, hire the minimal amount of staff . . . and admit patients for whom it is unable to provide adequate services." *Id.* at 6C. See also Carol M. Ostrom, *Puget Sound Hospital will Fight State's Closure Order*, SEATTLE TIMES, Apr. 2, 2000, at News (Washington's Department of Health closing a psychiatric hospital citing patient health and safety concerns after the hospital's parent corporation previously filed for bankruptcy).

¹⁹² Supplemental Response of the Debtor at 3, *In re Moshannon Valley Citizens, Inc.*, No. 06-00095 (Bankr. M.D. Pa. Mar. 22, 2006), 2006 WL 1201659.

¹⁹³ *Id.*

¹⁹⁴ *Id.*

debtor further claimed that because “[her] primary function at the Hospital is to monitor the quality of patient care and serve as a patient advocate” the appointment of an ombudsman would be redundant.¹⁹⁵ As more enticement, the debtor assured the court that the nurse would file reports to the court consistent with the requirements of the ombudsman provision.¹⁹⁶

In relevant part, the patient care ombudsman provision requires that “[i]f the court orders the appointment of an ombudsman . . . the United States trustee shall appoint 1 *disinterested* person . . . to serve.”¹⁹⁷ The Code defines, in part, a disinterested person as one who “is not and was not, within 2 years before the date of the filing of the petition, a director, officer, or employee of the debtor.”¹⁹⁸ A disinterested party also includes a person who “is not a creditor, an equity security holder, or an *insider*.”¹⁹⁹ Important for a corporate entity, an insider includes officers of the debtor.²⁰⁰ Finally, the Code defines a disinterested party as one who “does not have an interest materially adverse to the interest of the estate or of any class of creditors or equity security holders, by reason of any direct or indirect relationship to, connection with, or interest in, the debtor, or for any other reason.”²⁰¹

Congress clearly considered conflicts of interest in drafting the patient care ombudsman provision, given the statute’s “disinterested person” language.²⁰² Congress’s reasons for doing this are obvious. A significant decline in the quality of patient care or an event that impairs the interests of patient would create an interest adverse to the estate in the patients. Given this, courts should first consider whether to require the same level of disinterest from a debtor’s patient care advocate as it would from an ombudsman. Then courts should address whether to construe disinterest in a narrow or broad fashion.

¹⁹⁵ *Id.* at 4

¹⁹⁶ *Id.* at 5.

¹⁹⁷ 11 U.S.C.A. § 333(a)(2)(A) (West 2007) (emphasis added).

¹⁹⁸ *Id.* § 101(14)(B).

¹⁹⁹ *Id.* § 101(14)(A).

²⁰⁰ *Id.* § 101(31)(B)(ii).

²⁰¹ *Id.* § 101(14)(C).

²⁰² *Id.* § 333(a)(2)(A).

The debtor for *Moshannon Valley*, in establishing the qualifications of its patient safety officer, clearly established that she qualified as an employee of the debtor.²⁰³ As such, the patient safety officer at a minimum is not disinterested by way of her employment relationship. Other areas of the Code and case law provide essential insight to evaluate Moshannon Valley's "duplicative service" argument in light of the need for disinterestedness. The Code decrees that the trustee may employ a professional person "that do[es] not hold or represent an interest adverse to the estate, and that are disinterested persons."²⁰⁴ The court in *In re Roberts*²⁰⁵ determined that the term "interest adverse to the estate" had one of two meanings.²⁰⁶ The first possible meaning was "to possess or assert any economic interest that would tend to lessen the value of the bankruptcy estate or that would create either an actual or potential dispute in which the estate is a rival claimant."²⁰⁷ The second possible meaning was "to possess a predisposition under circumstances that render such a bias against the estate."²⁰⁸

The *Roberts* court also found that "[to] 'represent an adverse interest' means to serve as agent or attorney for any individual or entity holding such an adverse interest."²⁰⁹ More importantly, the court stated that the definition of "interest adverse to the estate" from *Roberts* "must be employed with an eye to the specific facts of each case, and with attention to circumstances which may impair a professional's ability to offer impartial, disinterested advice to his or her client."²¹⁰ While it is true that both of the previous cases involved attorneys in conflicts of interest, the courts carefully couched their findings in terms to encompass all professionals.²¹¹

²⁰³ Response of the Debtor, *supra* note 145, at 4–5.

²⁰⁴ 11 U.S.C.A. § 327(a) (West 2007).

²⁰⁵ 46 B.R. 815 (Bankr. D. Utah 1985), *aff'd in part, modified in part, and remanded in part*, 75 B.R. 402 (D. Utah 1987).

²⁰⁶ *Id.* at 827 (involving a law firm's failed to disclose a conflict created by representation of both the corporate debtor and representation of the individual debtors owners).

²⁰⁷ *Id.*

²⁰⁸ *Id.*

²⁰⁹ *Id.*

²¹⁰ I.G. Petroleum, L.L.C. v. Fenasci (*In re W. Delta Oil Co.*), 432 F.3d 347, 356 (5th Cir. 2005). The attorney failed to disclose a conflict of interest where the counsel was involved with the debtor and with investors interested in acquiring the debtor's assets. *Id.*

²¹¹ See generally *In re W. Delta*, 432 F.3d at 356 ("[T]his definition [requires] . . . attention to circumstances which may impair a professional's ability.") (emphasis added); accord generally *In re Roberts*, 46 B.R. at 827.

The debtor in *Moshannon Valley* argued that its patient safety officer's responsibilities include reporting patient care issues directly to the Pennsylvania Department of Health.²¹² Presumably, the officer's motivation, at least in part, for reporting patient care issues to the state would be to fulfill her role "as a patient advocate."²¹³ Given this, the patient safety officer would fail the *Roberts* "interest adverse to the estate" element by her representation of the debtor. The debtor listed several patient care issues that the patient safety officer would report to the state, which included adverse reactions to medications that harm the patient and serious incidents that temporarily or permanently harm the patient.²¹⁴ Each of these incidents could create an economic interest in the state to withhold state or federal funds from the debtor.²¹⁵

A few decisions articulate cogent rationale for not appointing an ombudsman.²¹⁶ For instance, the *Total Woman Healthcare Center* court stated that the "[r]espondent's financial distress has not affected patient care."²¹⁷ The court, in support of this proclamation, cited several factors.²¹⁸ First, the court noted that the debtor had only one physician, that it had all the equipment necessary for the physician's practice, and that no staff reductions had occurred.²¹⁹ Second, the court noted that no patient complaints had been received since the debtor's filing and that the physician continued to schedule patients without affect from the debtor's financial state.²²⁰ Third, the court assured that the physician understood that patient medical records must be maintained after the bankruptcy and that patients continued to have access to those records.²²¹ Finally, the court noted that the debtor's financial distress arose not from any obligation to a patient but from taxes.²²² From these

²¹² Supplemental Response of the Debtor, *supra* note 192, at 4.

²¹³ *Id.*

²¹⁴ *Id.*

²¹⁵ See *supra* notes 187–91 and accompanying text.

²¹⁶ See *In re Med. Assocs. of Pinellas, L.L.C.*, 360 B.R. 356 (Bankr. M.D. Fla. 2007); *In re Total Woman Healthcare Ctr., P.C.*, No. 06-52000 RFH, 2006 WL 370816 (Bankr. M.D. Ga. Dec. 14, 2006); *In re Banes*, 355 B.R. 532 (Bankr. M.D.N.C. 2006).

²¹⁷ *In re Total Woman Healthcare Ctr.*, 2006 WL 370816, at *2.

²¹⁸ *Id.*

²¹⁹ *Id.*

²²⁰ *Id.*

²²¹ *Id.*

²²² *Id.*

factors,²²³ the court concluded that an appointment of an ombudsman would not be necessary under the facts.²²⁴

The *Banes* court also found that because § 101(27A) is written with present tense language,²²⁵ Congress only intended to offer the ombudsman protection where the debtor actively continued to treat patients.²²⁶ Thus, the court found that the appointment would not be necessary where the debtor had stopped operations.²²⁷ The court went on to note that the Code allowed the trustee to carry out the mandates of those provisions that required monitoring the custody of patient records²²⁸ and the closing of the health care business,²²⁹ mitigating the need for an ombudsman to monitor those activities.²³⁰ The court in *Pinellas* obviated the need for an ombudsman to monitor the patient medical records by authorizing the debtor's member physicians to take custody of the records.²³¹ *Total Woman Healthcare Center, Banes, and Pinellas* demonstrate that when courts focus on patient care or issues that potentially affect patient care the likelihood of frustrating congressional intent is lessened greatly. Courts should then begin by assessing the degree to which the debtor's financial distress has adversely affected patient care.

²²³ It should be noted that in Georgia none of these factors would likely trigger an investigation by the Board of Medical Examiners. The Georgia Code section on physician disciplinary procedures focuses on acts of moral turpitude, malpractice, or malfeasance. It is not clear that actions adversely affecting patient care would rise to this standard. See generally GA. CODE ANN. § 43-34-37(a) (West 2007).

The board shall have authority to . . . discipline a physician licensed . . . upon a finding . . . that the licensee or applicant has: (7) Engaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice need not have resulted in actual injury to any person. As used in this paragraph, the term "unprofessional conduct" shall include any departure from, or failure to conform to, the minimal standards of acceptable and prevailing medical practice . . . (11) Committed any act or omission which is indicative of bad moral character or untrustworthiness . . .

Id. Because subclause 7 refers to "prevailing medical practice" in triggering the protections of the Georgia Code, the degree of deficient care necessary to appoint an ombudsman may not afford such state law sanctions, leaving patients without any recourse.

²²⁴ *In re Total Woman Healthcare Ctr.*, 2006 WL 3708164, at *3.

²²⁵ 11 U.S.C.A. § 101(27A) (West 2007) (defining a health care business with the phrases "is organized" and "is primarily engaged in offering").

²²⁶ *In re Banes*, 355 B.R. 532, 536 (Bankr. M.D.N.C. 2006); see also *In re Med. Assocs. of Pinellas, L.L.C.*, 360 B.R. 356, 361–62 (Bankr. M.D. Fla. 2007).

²²⁷ *In re Banes*, 355 B.R. at 536.

²²⁸ 11 U.S.C.A. § 351.

²²⁹ 11 U.S.C.A. § 503(b)(8).

²³⁰ *In re Banes*, 355 B.R. at 536.

²³¹ *In re Med. Assocs.*, 360 B.R. at 361.

C. *Factual Inquiry to Assess the Need for the Appointment of an Ombudsman*

Of important note, the ombudsman provision provides no mechanism for courts to investigate the facts of the case because the principle parties that the provision seeks to protect, the patients, have no voice in the proceedings. The Federal Rules of Bankruptcy Procedure provide that the court should make its determination about the appointment on motion from trustee or any party in interest.²³² However, that factual inquiry relies solely on the accuracy and completeness of the facts presented by the debtor, the trustee, or another party in interest. Congress may have expected the trustee to put on facts in support of patients' interests.²³³ To do so, the trustee must gather and present to the court a factual analysis very similar to that which an ombudsman would present.

The trustee's appointment to represent the facts detailing patients' interests raises two concerns. First, what data the trustee will rely on to make its factual analysis. The trustee in *Moshannon Valley* apparently relied solely on the filings and response of the debtor.²³⁴ Second, the trustee argued in *Moshannon Valley* that the ombudsman was the proper person to assess the facts surrounding the need for an appointment.²³⁵ These two points lead to the question of whether the trustee's office can handle the extra workload of making the factual assessment necessary to mount a case for the ombudsman.

Another concern in relying on the trustee's office arises when the court denies the appointment. In particular, can the trustee appeal an order denying the appointment. In determining who may appeal an order, bankruptcy courts apply the "person aggrieved" test.²³⁶ "The reasoning underlying this limitation on standing is to prevent bankruptcy litigation from becoming 'mired in endless appeals brought by the myriad of parties who are indirectly affected by every bankruptcy court order.'"²³⁷ While the court concluded that a person

²³² 2 NORTON, *supra* note 127, at 169.

²³³ *Cf.* Response of United States Trustee, *supra* note 139, at 4 (stating that the debtor provided insufficient information to analyze the need for an ombudsman).

²³⁴ *See id.* at 3–4 ("Debtor notes that it has been the subject of frequent inspections. . . . Debtor also acknowledged that it had a provisional license in 2001."). The Trustee also argued that opposing an appointment due to the financial impact on the debtor was impossible without filed financial statements. *Id.* at 4.

²³⁵ *Id.*

²³⁶ *In re Revco, D.S., Inc.*, 99 B.R. 778, 779 (N.D. Ohio 1989) (upholding denial of the appointment of an examiner when the appointment had been opposed by all parties).

²³⁷ *Id.* at 779 (quoting *Kane v. Johns-Manville Corp.* (*In re Johns-Manville Corp.*), 843 F.2d 636, 642 (2d Cir. 1988)).

was aggrieved if an order impaired his rights, they tied the aggrieved status to having a pecuniary interest directly or indirectly affected.²³⁸ More important, the court noted that the question of aggrieved status typically “arises in the context of a hopelessly insolvent debtor or *marginal parties* in a bankruptcy proceeding, the same test applies in this case in relation to the U. S. Trustee.”²³⁹ Thus, the ombudsman, appointed specifically for this purpose, may be in both a better position to present a factual analysis of patient interests and be better suited to appeal adverse decisions affecting those interests.

Because courts, generally, lack the expertise to adjudge a debtor’s quality of care, they should consider the value of appointing an ombudsman as a default position. First, the ombudsman would prove valuable in providing an independent view of how the debtor’s financial distress is affecting or potentially will affect patient care. Second, the ombudsman would be better suited to provide an actual analysis of patient care and represent those interests should the court decide adversely to those interests.

III. A PROPOSAL FOR ADDRESSING THE APPOINTMENT OF THE PATIENT CARE OMBUDSMAN

“This legislation takes great strides to protect patients’ rights, and it encourages debtors and trustees to consider patients’ interests when administering healthcare bankruptcy cases. Patients are given a voice through the appointment of an ombudsman. . . .”²⁴⁰ “It protects patient privacy and care during bankruptcy proceedings that involve health care facilities.”²⁴¹

The first difficulty courts find in implementing Congress’s protections derives from the Code’s confusing and contradictory definition of “health care business.” While patients are the primary focus of the health care business amendments, the definition of “health care business” conspicuously fails to refer to patients. Instead, the definition employs the amorphous term “general public.” Courts urge that “general public” does not include health care providers who restrict their clientele. However, this argument ignores the reality of modern day health care. Few health care providers provide services

²³⁸ *Id.*

²³⁹ *Id.* (emphasis added).

²⁴⁰ 151 CONG. REC. H2065 (daily ed. Apr. 14, 2005) (statement of Rep. Kirk) (referring to the legislation that would become BAPCPA).

²⁴¹ 151 CONG. REC. S2199–2200 (daily ed. Mar. 8, 2005) (statement of Sen. Frist) (referring to the legislation that would become BAPCPA).

without the order of a physician. Thus, courts' construction of the definition of "health care business" and "general public" cuts from protection nearly all patient care providers. The courts' reasoning ignores Judge Hand's admonishment not to be caught in the trap of language which is too broad or too narrow to accomplish a patent legislative purpose. The patent legislative purpose Congress intended for the health care amendments is the protection of patients. In other words, the courts' definition narrowly construes the definition of a health care business, seeing a windmill where Congress probably saw a giant. The courts, instead, should construe "general public" in a way that includes businesses providing direct patient care services.

Congress also provided a list of exemplary health care businesses. Unfortunately, the list contains businesses that cannot meet previously stated qualifications to be named a "health care business." Courts argue that businesses must meet all of Congress's requirements to fall under the statute's definition because those requirements are linked by the term "and." However, in doing so, they ignore the internal inconsistencies of the statute. The most glaring inconsistency is that home health agencies do not provide both "facilities and services" to their patients. Yet, those businesses are explicitly included in Congress's list of health care businesses. Adding to the confusion, courts add their own requirements to the statute. Courts urge that Congress's list of health care businesses clearly meant to target only those businesses that provided ongoing care, shelter, and sustenance to patients. However, this construction clearly ignores the nature of some of the examples Congress provided, such as ancillary ambulatory, emergency, or surgical treatment facilities. None of the foregoing facilities provide ongoing care, shelter, and sustenance to patients. Here again, the courts tilted at windmills when the giants were clearly before them. Courts, in determining whether a debtor fits the definition of a "health care business," should not misconstrue the nature of the facilities and services listed in § 101(27A).

The Code's primary patient protection, the patient care ombudsman provision, provides fertile ground for courts and parties to tilt against windmills. Bankruptcy observers worry about over-zealous ombudsman reacting to patient conditions that do not reach the life threatening level. While Congress did not indicate what constitutes adverse patient care, they very likely did not intend a grossly adverse standard. Admittedly, Congress did not provide any evidence of a clear standard. *Total Woman Healthcare Center* presents the most coherent analysis of patient care thus far. Taking from that and other opinions, courts should generally assess the degree to which the

debtor's financial distress has adversely affected patient care. Courts would then apply that analysis to the following issues: (1) is the debtor able to maintain equipment necessary for the delivery of patient care; (2) has the debtor made staff reductions such that patient care would be adversely affected; (3) has the debtor received patient complaints regarding the delivery of care; (4) are the debtor's medical records being maintained; (5) does the debtor's financial distress result from patient obligations; (6) is the debtor maintaining its medical malpractice insurance; (7) is the debtor no longer engaged in patient care services. This analysis relies heavily on the veracity of the debtor. Courts can normally expect an honest airing of the facts from the debtor. However, *Baltimore Emergency Services*²⁴² warns against the universality of that expectation. Though the over-zealous ombudsman does pose a risk, the courts ability to control, the need for an unbiased airing of the facts, and the expertise they can provide to the court outweighs the risk potential.

While important to assessing its affect on patient care, Congress clearly did not consider the debtor's financial status or ability to compensate the ombudsman as relevant. First, the ombudsman provision fails to address this factor explicitly. Second, the Code's compensation provision does not mention the debtor's ability to compensate the ombudsman as a factor in the court's analysis of compensation. The provision does allow the court to limit the compensation to reasonable and necessary expenses. These limitations provide the court with ample control over the ombudsman's impact on the debtor's finances. Courts and interested parties would likely argue that, given the traditional focus of the Bankruptcy Code, the financial status of the debtor is implicitly a factor in the appointment of the ombudsman. However, Congress' specific concern for patients being adversely affected by the debtor's bankruptcy decries that it was precisely the fact that the debtor's was in financial trouble that lead to the promulgation of the health care business amendments. Further, the debtor who presents with great financial trouble is the debtor who very likely presents the greatest hazard to patient care. Thus, courts must avoid tilting at the debtor's ability to compensate the debtor in determining whether the appointment of an ombudsman is necessary.

²⁴² See generally *In re Baltimore Emergency Services II, LLC*, 334 B.R. 164, 168 (Bankr. D. Md. 2005). The debtor maintained one medical malpractice policy fully paid, but they failed to make the full monthly deductible deposits on a second, self-funded policy. The debtors' Chief Restructuring officer decided against making full payments to the second plan because of cash flow problems. The reorganization plan projected the coverage to be \$18.7 million, but the actual funding, after the shortfall payments, came to between \$13.1 and \$13.5 million.

Another tantalizing mark for judicial attention, internal oversight measures by the debtor provide courts the protective measures of the ombudsman without the extra cost to the debtor. Unfortunately, the ombudsman provision clearly indicates Congress' intent in having a disinterested party monitor patient care and represent patient interests. Congress, in seeking disinterestedness, very likely sought a person who could assess care and represent interests without concern for the effect on the debtor's assets or the creditor's payout. An employee of the debtor does not fit the Code's definition of disinterested party. External oversight presents a closer call for courts. State and federal agencies heavily regulate the health care industry. Courts should address two concerns with external oversight of the debtor. First, agencies may not provide the timely or regular oversight afforded by the ombudsman. Second, courts have direct control over when, how, the contents of, and the procedures for the ombudsman's report to the court.

CONCLUSION

Congress promulgated health care business amendments to the Code in the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005. Because Congress felt patients were especially vulnerable to the conditions created by a health care provider's failing financial status, they sought to protect patients from the inequities created by the bankruptcy of their health care provider. However, the health care business amendments differ drastically from most other provisions in the Code. First, the Code's primary purpose seeks to protect and convert debtor assets for the benefit of creditors. Chiefly, the health care business amendments focus on parties who have no financial interest in the bankrupt entity. The amendments seek, however, to draw the court's attention away from debtor and creditor interests and place that attention on the needs of patients. Second, the patient and health provider relationships, unlike most debtor/creditor relationships, are not arms length transactions.

Finally, consider again Don Quixote's adventure of the windmills in light of Judge Hand's call to interpret statutory provisions neither too broadly nor too narrowly. A tilt against windmills, then, occurs when a construction is reached that fails to achieve the patent legislative purpose of a statute. Therefore, courts should address the appointment of a patient care ombudsman by starting from the premise that Congress intended the appointment as the

default and only where the facts indicate adequate protection of patients should courts forego the appointment.

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