NO. 24-483

IN THE
# Supreme Court of the United States

SANDHILLS MEDICAL FOUNDATION, INC.,
*Petitioner*,
v.
JOANN FORD, ET AL.,
*Respondent*.

On Petition for a Writ of Certiorari
to the United States Court of Appeals
for the Fourth Circuit

## REPLY BRIEF IN SUPPORT OF CERTIORARI

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## REPLY BRIEF IN SUPPORT OF CERTIORARI

The petition asks the Court to resolve a conflict between the Fourth and Ninth Circuits regarding the reach of a Public Health Service (PHS) Act provision that immunizes PHS employees—and those deemed equivalent—from actions "resulting from the performance of medical, surgical, dental, or related functions." 42 U.S.C. § 233(a). The Fourth Circuit, applying a "limiting principle," App. 21a, to PHS Act immunity, construed "related functions" to mean conduct in "a field of health care outside of medicine, surgery, or dentistry," App. 18a. The decision constricts a "comprehensive immunity" right, *Hui v. Castenada,* 559 U.S. 799, 810 (2010), to mere medical malpractice coverage, protecting PHS employees only from suits based on their "performance of the provision of health care." App. 20a. The Ninth Circuit, in contrast, held the PHS Act plainly confers immunity for actions resulting from functions *related* to medical care, as "[a]ny other reading would render the 'related functions' language in the statute superfluous." *Friedenberg v. Lane County*, 68 F.4th 1113, 1128, 1130 (9th Cir. 2023).

The briefs in opposition attempt to obscure the split, reframing the question presented as a narrow, fact-bound issue. As the petition and amici establish, the conflicting constructions of "related functions"—decided based on nearly identical arguments—reach far beyond their facts. The government's arguments against review reveal its design: to preserve the Fourth Circuit's curtailment of official immunity and replicate it in other circuits.

While the merits are best addressed on plenary review, respondents offer no persuasive defense of the Fourth Circuit's departure from bedrock principles of statutory interpretation and a natural reading of § 233(a). They likewise fail to defend the Fourth Circuit's ultimate determination that a federally-funded clinic's protection of patient confidentiality is unrelated to medical care.

Because of the conflicting interpretations of statutory language, official immunity for deemed and actual federal employees—in the nationwide health care safety net—differs markedly based on geographic happenstance. That is precisely the kind of conflict this Court should resolve.

The Court should grant the petition.

## I. This case is a good vehicle to resolve a clear split on the scope of PHS Act immunity

As the petition explained, this is an ideal vehicle to resolve a discrete and cleanly packaged question of statutory construction on which the Fourth and Ninth Circuits are in direct conflict. Pet. at 6–11. Respondents cannot show otherwise.

To avoid review, respondents downplay the extent and significance of the circuit split. The government contends—incorrectly—that the decision below does not conflict with decisions of this Court or the other courts of appeals. U.S. Br. at 8. Plaintiff goes a step further, remarkably asserting the conflicting

decisions "are perfectly consistent with each other." Doe Br. at 10. Neither assertion is credible.

The conflict among the lower courts is clear and direct. The decision below narrowly construed "related functions" to mean activity in "a field of health care outside of medicine, surgery, or dentistry," App. 18a, such that § 233(a) immunizes only the "performance of the provision of health care." App. 20a. The Ninth Circuit construed the same language to mean what it plainly says: functions *related* to medical functions, expressly rejecting the "proposition that § 233 immunity applies only when the injury occurs 'during the provision of medical treatment to a patient.'" *Friedenberg*, 68 F.4th at 1129 (concluding construction would impermissibly "ignore the statutory text"). The two holdings cannot be reconciled.

The government cherry picks portions of *Friedenberg* to obscure the conflict, U.S. Br. at 10, ignoring entirely the Ninth Circuit's careful work to "define[] the scope of § 233" before "consider[ing] whether it applie[d] in [that] case." *Friedenberg*, 68 F.4th at 1128; *see id.* at 1124–28 (defining scope of § 233(a) immunity, including by interpreting "related functions," as "a matter of first impression in our circuit"). In construing "medical . . . or related functions," the Ninth Circuit explicitly declined to narrow § 233(a)'s comprehensive immunity to medical malpractice or misfeasance, observing that such a reading would render "related functions" superfluous. *Id.* at 1128 ("Congress, in drafting the statute, failed to use plain language limiting the statute to medical malpractice suits . . . .") (citation omitted).

In direct conflict, as each opposition makes clear, the Fourth Circuit's rule *does* limit the statute's coverage to "health-care related claims typified by 'medical malpractice' torts." U.S. Br. at 10; *see id.* at 8 (describing § 233(a) as providing a "*limited* grant of immunity to federally funded health centers") (emphasis added). That is exactly the (rejected) interpretation of § 233(a) the government asked the Ninth Circuit to adopt. *See* U.S. Br. at 36, *Friedenberg*, *supra* (No. 21-35078) (filed Aug. 9, 2021) ("[H]ealth centers are only covered for 'services provided' to individuals receiving medical treatment . . . . The statute describes this as coverage for 'medical malpractice liability.'"), 37 ("Congress understood the protections afforded under the Act to be limited to medical malpractice coverage.").

Respondents' attempts to isolate the decision's reach and impact are not credible. The decision below is neither "fact-bound," U.S. Br. at 10, nor confined to claims asserting breaches of confidentiality or patient privacy, Doe Br. at 10. The acts and omissions alleged in *Friedenberg*, analyzed today in the Fourth Circuit, would almost certainly—and wrongly (and at the government's urging no less)—result in a denial of official immunity. Reporting a patient's refusal to comply with the medical terms of his court-ordered probation is not conduct in "a field of health care outside of medicine, surgery, or dentistry." App. 18a. It is, however, conduct "intertwined . . . with [the] provision of medical services," *Friedenberg*, 68 F.4th at 1130, *i.e.*, involving "related functions" within the meaning of § 233(a).

Tellingly, while arguments in *Friedenberg* that the conduct at issue was "administrative," rather than medical, were unpersuasive to the Ninth Circuit, the same arguments—asserted in part in strikingly similar government briefs—carried the day below. The nature of the conduct did not drive the different outcomes; the conflicting interpretations of "related functions" did. Both *Friedenberg* and this case arose from deemed PHS employees' performance of health-related functions, rather than from the provision of direct patient care. Reporting obligations, like the protection of patient confidentiality, involve administrative or operational functions "tied to [providers'] status as medical health professionals." *Friedenberg*, 68 F.4th at 1130; *see Krandle v. Refuah Health Ctr., Inc.*, No. 22-cv-4977, 2024 WL 1075359, at *4, *9 (S.D.N.Y. Mar. 12, 2024) (publication forthcoming) (rejecting government argument that § 233(a) "is generally directed towards 'misfeasance' in the provision of healthcare," and concluding that securing patient data from internal and external threats is an immunized "related function" required of health centers by statute and "essential to the practice of medicine").

Underlying the Fourth and Ninth Circuits' conflicting interpretations is the proper application of this Court's statutory construction precedent. Pet. at 11–17. The Ninth Circuit's decision faithfully applies this Court's teachings. The decision below does not. Pet. at 13. Neither respondent meaningfully disputes this point.

## II. Neither Respondent confronts, much less disputes, the importance of the issue presented

Respondents do not, and cannot, dispute the importance of the question presented, or otherwise justify percolation. The recurring issue presented has the potential to negatively impact safety net providers serving more than 31 million Americans. Amici Br. at 4. Health centers like Sandhills must, by law, "focus exclusively on communities and populations designated as medically underserved by virtue of their poverty and the heightened health risks triggered by such poverty." *Id.* at 5 ("Over 67 percent of patients . . . served in 2023 lived below the official federal poverty line, and almost 90 percent lived below twice poverty."). As amici attest, the decision below "will have profoundly detrimental effects on [community health centers] and their patients." *Id.* at 17–18. In short, the Fourth Circuit's rule threatens health centers' ability "to provide . . . high-quality care in the many medically underserved communities where they operate." *Id.* at 7. Neither plaintiff nor the government mention or respond to any of amici's arguments. The silence is striking.

Respondents likewise do not meaningfully dispute that the split authority on the meaning of "related functions" in § 233(a) subjects both deemed and actual PHS employees asserting official immunity to vastly different litigation and liability outcomes based solely on geography. Pet. at 19. The reason for the government's silence lies in plain sight: the Solicitor General's position in the *Hui* litigation, selectively cited in the government's opposition. U.S.

Br. at 12.[1] There, in urging review to resolve a 1-1 split, the government acknowledged the "PHS conducts nationwide operations that should be subject to uniform immunity rules" and asserted § 233(a) immunity "is of material importance" to both actual and deemed PHS personnel and operations. *See* U.S. Amicus Br. at 9, *Hui*, *supra* 559 U.S. 799 (No. 08-1529), 2009 WL 2009352 (July 10, 2009) (noting actual and deemed PHS have "the same immunity").

Finally, the government contends review is premature "because other courts of appeals have not weighed in on the question presented and will do so in the near future." U.S. Br. at 10. The unsupported assertion is patently false: two courts of appeal have provided directly opposing interpretations of the meaning of "medical . . . or related functions" and, based on those interpretations, the scope of § 233(a)'s immunized conduct. While the Eighth Circuit, too, will indeed soon consider the breadth of § 233(a) immunity, that appeal, like the other active cases noted in the petition, Pet. at 20 n.7, demonstrate the issue is recurring and in need of resolution, rather than the opposite. The rote call for percolation is not only unsupported, but also made without any effort to address why the significant harm inherent in further delay, Pet. at 19–22, is tolerable in the interim.

[1] The government's citation is to its amicus brief supporting petitioners on the merits, filed on December 11, 2009.

## III. The decision below is wrong

Neither respondent offers a persuasive defense of the Fourth Circuit's narrow interpretation of "related functions" or its application of that interpretation to the alleged conduct at issue.

The government's opposition leans heavily on the word "malpractice"—which appears nowhere in § 233(a) itself—to shore up the Fourth Circuit's construction of "related functions," arguing the immunity should cover only "torts that arise *uniquely* in the health care setting" or claims "typified by 'medical malpractice' torts." U.S. Br. at 9–10. Nothing in the PHS Act supports that constriction of official immunity. *See Friedenberg*, 68 F.4th at 1127 (rejecting argument); *Cuoco v. Moritsugu*, 222 F.3d 99, 108 (2d Cir. 2000) ("There is nothing in the language of § 233(a) to support that conclusion."). Although "malpractice" does appear in the PHS Act, the Act expressly differentiates between malpractice and other types of claims. For example, § 233(h)(1)—a provision respondents conspicuously ignore—requires all health centers, as a condition of PHS status, to "implement[] policies and procedures to reduce the risk of malpractice *and* the risk of lawsuits arising out of any health *or health-related functions* performed by the entity." 42 U.S.C. § 233(h)(1) (emphasis added). This lawsuit plainly arises out of a deemed health center's "health or health-related functions."

Plaintiff similarly argues that "data security"—*i.e.*, protecting patient information against unauthorized disclosure—cannot be a "related

function" because it is "necessary for businesses of all stripes from health care centers to banks to state universities to retail chains." Doe Br. at 14 (asserting "[d]ata security is a lay, non-medical specific, function"). The argument ignores plaintiff's own theory of her case, which is premised on the fundamental difference between the "special" patient-provider relationship and other arms-length commercial transactions. The confidentiality and trust, on which the former depends, creates a fiduciary relationship that does not arise in the latter absent extraordinary circumstances. *See Krandle*, 2024 WL 1075359, at *10 ("If someone blurts out sensitive medical information while ordering food at a restaurant, the server need not safeguard that information.") (citing *In re Mid-Island Hosp., Inc.*, 276 F.3d 123, 130 (2d Cir. 2002) ("[W]hen parties deal at arms length in a commercial transaction, no relation of confidence or trust sufficient to find the existence of a fiduciary relationship will arise absent extraordinary circumstances.").

Stripping away the Fourth Circuit's outcome-motivated construction of § 233(a), it takes little effort to recognize that functions necessary to protect the confidentiality of patient information are closely "related" to medical functions. The respondents' characterizations of such activity as "divorced from the treatment setting," U.S. Br. at 10, and "the province of IT professionals, not medical professionals," Doe Br. at 14, does not survive scrutiny. The government's own statutorily-prescribed "application" for deemed PHS status expressly ties confidentiality to the provision of health care: identifying compliance with "(HIPAA)

and other applicable medical record confidentiality requirements" as one of the "areas/activities of highest *clinical risk* for the health center." HHS, Health Resources and Services Administration, Calendar Year 2026 Requirements for [FTCA] Coverage for Health Centers and Their Covered Individuals at 12–14, https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/pal-2025-01.pdf (emphasis added).[2]

The relationship between a deemed health center's clinical and confidentiality functions is likewise evident in HHS's requirement that health center applicants verify, under penalty of perjury, that they have "annual risk management training plans for all staff . . . based on identified areas/activities of highest clinical risk." *Id.* at 15. The required staff-wide training to mitigate "clinical risk" explicitly includes "training in [HIPAA] and other applicable medical record confidentiality requirements." *Id.* at 12 (requiring health centers provide HHS a copy of their training plans). Finally, HHS views health centers' implementation and maintenance of "systems and procedures for protecting the confidentiality of patient information" as so critical to its decision whether to extend deemed

[2] The application is "prescribe[d]" by the department head who has "expertise in administering healthcare policies and services." *Blumberger v. Tilley*, 115 F.4th 1113, 1128 (9th Cir. 2024); *see* 42 U.S.C. § 233(g)(1)(D) (providing Secretary "shall prescribe" an application "to verify" compliance with § 233(h)(1), among other provisions). The Secretary issues a new deeming application each calendar year. The available CY 2026 iteration—which postdates the events at issue—illustrates HHS's increasing emphasis on safeguarding patient information.

PHS employee status, that a failure to do so, and to "safeguard this information against loss, destruction, or unauthorized use" is grounds for denying a health center "deemed" PHS employee status, and thus the absolute immunity protection of § 233(a). *Id.* at 21.

Finally, as the Ninth Circuit recognized, in properly construing the statute, courts have repeatedly recognized that cross-cutting functions—such as taking adequate care in employee hiring and supervision, recordkeeping, and reporting suspected child abuse and neglect—although *not uniquely* connected to the performance of medical functions, are nonetheless sufficiently "related" to medical functions to fall within PHS Act immunity. *See Friedenberg*, 68 F.4th at 1129 (collecting cases arising out of "related functions"). As it did in *Friedenberg*, the United States argues here that there is "no sound basis" to cover claims resulting from "administrative or operation[al] duties related to medical care," such as "hiring" and "case management." U.S. Br. at 10. By arguing against coverage of the very conduct the Ninth Circuit endorsed as examples of "related functions," the United States belies its "fact-bound" characterization of the decision below, emphasizing the need to resolve the conflicting "understanding of Section 233(a)'s sweep." *Id.*

## CONCLUSION

For the foregoing reasons and those stated in the petition for a writ of certiorari, the petition should be granted.

Respectfully submitted,

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