present case reinforces the federal position framing the nature of PDMPs as primarily tools of law enforcement. It argues against patients' and physicians' expectations of privacy concerning prescription records stored by a PDMP.

The DEA has argued the primary purpose of a PDMP is to identify and deter or prevent drug abuse and diversion. PDMPs originally collected only Schedule II substance information. Electronic reporting has enhanced the ability to collect and store PDMP information. In this context, data collection has expanded beyond Schedule II drugs. In an *amicus* brief in this case, the American Medical Association (AMA) stated, "The primary purpose of PDMPs is health care, not law enforcement" (Brief for AMA *et al.* as Amici Curiae Supporting Petitioners at 20, *Oregon PDMP v. DEA*, 860 F.3d 1228 (9th Cir. 2017)). However, this argument is found nowhere in the statute establishing Oregon's PDMP (Or. Rev. Stat. § 431A.855 (2015)). The AMA stated it hoped to prevent patient prescription data from becoming a "law enforcement tool" without "stringent legal requirements for disclosure" (Brief for the AMA, p 2). These arguments were not persuasive to the court in the present matter.

The DEA's argument relied partly on a "third party" doctrine that when a physician writes a prescription, he voluntarily presents individual prescribing data to a pharmacist. The DEA argues that the physician has relinquished some privacy interest. Similarly, the DEA argued a patient who chooses to fill a prescription has relinquished some privacy interest. The inability of the intervenors in this case to establish standing to bring action resulted in the appeals court's not ruling on matters related to the privacy interests they had raised. The holding in *Whalen* addressed many of the same potential concerns and strictly limited the "constitutionally protected 'zone of privacy'" when balancing the privacy of health information versus the needs of law enforcement (*Whalen*, pp 603–604). These decisions have potential implications for future actions by patients and physicians to limit government monitoring and use of data from federal and state databases. Physicians should assume that records in PDMPs can be routinely analyzed by government agencies.

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Death Following Sports Concussion and Interstate Medical Negligence Claim

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In Youth Concussion Wrongful Death Case, Negligence Claims Against School Remanded for Review but Interstate Medical Negligence Claim Not Reviewed for Lack of Jurisdiction

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Andrew (Drew) Swank, a high school junior on a football team in Washington State, died after he sustained a second impact injury within one week. Days after his first injury, a physician concluded that Drew he had sustained a concussion and cautioned against returning to play if his headaches persisted. The day before his next game, his headaches resolved, and the physician cleared him to play. During the game, he demonstrated symptoms of an unresolved concussion, collapsed after a hard impact, and died two days later. In *Swank v. Valley Christian School*, 398 P.3d 1108 (Wash. 2017), the Washington Supreme Court affirmed the trial court's dismissal of the medical negligence claim against the physician. The court found that the state's recently passed law, which restricts a youth's participation in sports if suspected of having sustained a concussion, warranted a cause of action for negligence against the high school and coach. As such, the case was remanded for reconsideration of this claim.

Facts of the Case

Drew Swank was a high school junior and football player at Valley Christian School (VCS). On Friday, September 18, 2009, he sustained an impact during a game and developed neck pain and a headache. He was removed from play. On Monday, he continued to experience headaches and did not attend school or practice. On Tuesday, Dr. Burns, the Swanks' primary care physician, diagnosed a mild concussion. The doctor recommended that Drew refrain from participating in contact sports for three days and if

his headache returned after playing football, that he stop playing for one week. Dr. Burns completed his family medicine residency in Washington in 1989. The Swanks met him in the early 1990s. Since 2003, Dr. Burns had been licensed to practice medicine only in Idaho. All care Dr. Burns provided to Drew took place in Idaho. A small percentage of Dr. Burns' patients were Washington residents for whom he occasionally sent prescriptions to Washington pharmacies. The family practice corporation, where Dr. Burns worked, used laboratories in Washington and contracted with Washington insurance companies.

Dr. Burns wrote a note on Thursday clearing Drew to return to play on Friday, September 25, 2009, after his mother called the clinic to report that the headaches had resolved. Mrs. Swank cited Washington's new Lystedt Law, Wash. Rev. Code § 28A.600.190 (2009), which required a physician's assessment and release before an athlete could return to sports participation after sustaining a concussion. The impetus for this law arose in 2006, when Zackery Lystedt suffered a head injury during a middle school football game and returned to play without first being evaluated by a licensed health care professional. After the game, he collapsed and required life-saving brain surgery. Washington's legislature passed the Lystedt Law in May 2009, which was the first law of its kind in the nation.

During Drew's last football game on Friday, September 25, 2009, his father, aunt, and teammates observed his performance declining during the game. His coach, Mr. Puryear, confronted him about the quality of his performance on multiple occasions, but permitted him to return to the game. During the game, Drew collided with an opposing player, collapsed off the field, and died two days later. In September 2012, Drew's parents filed a wrongful death suit against Dr. Burns, VCS, and Mr. Puryear. They asserted causes of action for medical negligence, negligence, and violation of the Lystedt Law. The trial court granted summary judgment in favor of the defendants on all claims. The Washington State Court of Appeals affirmed this summary judgment on all claims except for a general negligence claim against VCS. The Swanks appealed to the Washington Supreme Court.

Ruling and Reasoning

The Washington Supreme Court affirmed the holdings of both lower courts regarding the lack of personal jurisdiction over Dr. Burns. In its reasoning, the court cited an exception to Washington's long-arm statute, Wash. Rev. Code § 4.28.185 (2011), recognized in *Lewis v. Bours*, 835 P.2d 221 (Wash. 1992), and the court's reasoning in *Grange Insurance Ass'n v. State*, 757 P.2d 933 (Wash. 1988). The long-arm statute specifies that, irrespective of a person's out-of-state residential status, the state court may exercise jurisdiction over someone who commits a tortious act in Washington. A question of personal jurisdiction over Dr. Burns was raised because he had provided all medical care to Drew in Idaho, although the injury occurred in Washington. The court acknowledged that, for the purposes of the long-arm statute, Washington had generally recognized an injury as "an inseparable part of the 'tortious act'" (*Grange*, p 936), and hence, regarded the corresponding act to fall under the Washington court's jurisdiction. In *Lewis*, however, the court found that an exception to this long-arm statute interpretation applied to professional malpractice.

In *Lewis*, Ms. Lewis had given birth to a baby in Oregon, was discharged home to Washington, and during the drive home, the baby had complications. Ms. Lewis argued that Dr. Bours' tortious act occurred in Washington because the baby's injury arose in Washington. The Washington court declined to review this claim and found an exception to the act–injury inseparability doctrine, reasoning that the provision of medical care is a personal service and, unlike the sale of goods, is strongly tied to the location where the services were performed. The precedent for this reasoning came from the *Grange Insurance* case, in which the court determined it lacked personal jurisdiction over a veterinarian who examined cattle in Idaho that later developed and spread disease after delivery to Washington. Citing *Grange*, the court said: "the rendition of services is more personal in nature than is the sale of goods, such that the location where the services are performed is of greater jurisdictional importance than is the location where a product is bought" (*Grange*, p 939). The court added a policy basis for this decision, noting that availability of medical services "might be inhibited if doctors were worried about having to defend malpractice suits in distant states" (*Grange*, p 939). The Swanks attempted to distinguish the *Grange* case and argued that Dr. Burns had released Drew to play football for a school in Washington to fulfill requirements outlined by a Washington law, and therefore, the pro-

fessional services exception in *Grange* did not apply. The court rejected this argument and reflected that Dr. Burns had examined Drew in Idaho, created his clearance letter in Idaho, and left this letter in his Idaho office for Drew's parents to retrieve. All medical care that Dr. Burns provided Drew was in Idaho, and any tortious act had therefore occurred in Idaho.

Discussion

Washington's Lystedt Law, passed in 2009, requires a youth suspected of having sustained a concussion or head injury be removed from sports participation. The Lystedt Law requires that the youth return to play only after clearance by a licensed health professional. It requires school districts to educate coaches, youth, and parents of risks of playing sports with an unresolved concussion. As of January 2014, the other 49 states and District of Columbia have adopted laws that embody the standards of the Lystedt Law. The nationwide adoption of versions of this law represents progress in aligning the law with the medical community's interest in protecting athletes from short- and long-term risks of head injury. The present case highlights the importance of appropriately managing concussed young athletes, the implications for health care professionals involved in their care and monitoring, and the potential liability for parties who have roles and responsibilities defined by such laws.

The present case demonstrates the need for physicians to be cognizant of laws governing specific evaluations. For example, before writing a letter, such as in this case, the physician should understand the purpose for which it will be used, the nature of the law requiring the letter, what information must be included in the letter, and whether the physician possesses the expertise to address the needs of the patient's case. It also highlights potential hazards of providing care to individuals who reside in a different state than where they are receiving care. This case suggests that physicians providing treatment in such situations must know the laws related to medical practice in their state, as well as the state in which the patient resides. Finally, this case highlights the need for physicians to understand their potential liability when providing treatment in such situations. For instance, it is worth noting that courts in Mississippi, South Dakota, and Ohio have ruled similarly regarding lack of personal jurisdiction over an out-of-state physician (Key CM: Personal jurisdiction and choice of law in interstate medical practice not settled issues. *ABA Health eSource* 7.10 (2011). Available at: https://www.americanbar.org/newsletter/publications/aba_health_esource_home/aba_health_law_esource_1106_key.html. Accessed December 28, 2017). On the contrary, courts in Idaho and Mississippi have exercised jurisdiction over foreign state physicians in the respective contexts of Idaho's exclusive statute prohibiting services to out-of-state residents (Idaho Code § 54-1804(1)(2011)) and an Alabama physician's involvement with Mississippi insurers, health care providers, and its government (Key CM: *ABA Health eSource* 7.10 (2011)).

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