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COLLEGE OF LAW

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ELECTRONIC MEDICAL RECORDS: THE PRESIDENT'S CALL FOR NATIONAL ADOPTION

In January 2005, President Bush called for the national adoption of Electronic Medical Records (EMRs), also known as Electronic Health Records (EHRs), because the system "would lead to fewer dangerous medical mistakes, reduce costs and improve care." This idea is not new. In the 1990s, Community Health Information Networks (CHINs) allowed physicians, hospitals and other providers to electronically share information, but this system was unsuccessful. Proponents of new EMR systems refer to them as Regional Health Information Organizations (RHIOs).

Currently, about 5% of the country's practicing physicians use a full EMR system, and more than 50% of US hospitals plan to add EMR systems within the next 2 years. These systems allow health care providers to turn all new paperwork, as well as convert all older information, into electronic data. The electronic records include health data sheets, medical histories, demographic information, HIPAA consents, insurance information and cards, internal documentation, physicians' notes, lab tests and results, telephone or email messages, prescriptions, and billing folders.

Physicians and administrators are divided on using an EMR system with the current technology. An EMR system allows physicians to access charts from any location (home, hospital, office, conference) and, therefore, allows them to review and electronically sign off on the chart or make notes without any information ever leaving the patient's file, reducing lost or misfiled paperwork. The system would provide physicians instant access to patient records and even allow prescriptions to be written and sent immediately to the patient's pharmacy, simultaneously entering the prescription information into the patient's chart. The system can help with insurance and billing, including assuring that an accurate billing is generated from each visit. Laboratories, physicians, and specialists can communicate more easily. It may even improve patient involvement in their own care, if patients are able to make lab test appointments or look over their records online, as well as click on "electronic links to learn more information about their medical conditions."

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From Selma to Washington: Disentangling Fact from Fiction
The Realities of Unequal Health Treatment

On March 5, 2005, DePaul University College of Law's Journal of Health Care Law and Center for Race and Bioethics co-sponsored an event with Rainbow PUSH entitled: "From Selma to Washington: Disentangling Fact from Fiction – The Realities of Unequal Health Treatment". The day began with a nationally televised Congressional Town Hall Meeting moderated by Reverend Jesse Jackson Sr.

Rev. Jackson lauded DePaul and all involved in the symposium for their work in spreading the message of Rev. Dr. Martin Luther King, Jr. that discrimination within our health care system will no longer be tolerated. He quoted Rev. King as saying, "Of all the forms of inequality, injustice in health care is the most shocking and inhuman." The answer to discriminatory health care that is proposed by Rev. Jackson is action in the form of "legislation, litigation, registration, and demonstration."

Also discussed at the Town Hall Meeting was a recent study that demonstrated racial redlining in investment at various Chicago-area branches of Advocate Hospitals. "Racial redlining" refers to the practice of drawing a red line around predominately-African American communities and refusing to lend money in these areas. The study shows, for one, that Advocate Good Shepherd hospital and Advocate Bethany Hospital, while similarly sized, received remarkably different financial support. The former serves a patient population that is 96% white while the latter serves a population that is 97% black.

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What's the Remedy?

Making Prescription Drugs Affordable to All Americans

April 12, 2005, 5:00 p.m.

DePaul University (Lincoln Park Campus)

A conversation examining policy and strategies to improve access to medications

- Marilyn Moon, PhD, Vice President and Director of the Health Program, American Institutes for Research

- Edmund Haislmaier, Visiting Research Fellow, Center for Health Policy Studies, Heritage Foundation

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EMR systems provide systematized office practices; standardized practices reduce errors and increase patient safety. Reducing reliance on memory also improves safety, and an EMR system ensures all gaps are covered. Furthermore, "an EMR system helps to eliminate common problems like incomplete or unavailable charts, lab test and X-ray mix-ups, and errors relating to medications, filing, and diagnostic imaging." Errors from deciphering illegible handwriting are also reduced since notes and other information, including prescriptions, are typed into the file, or clicked on from a list of options.

While civil liberty groups have raised concerns about confidentiality of records, proponents claim an EMR system preserves confidentiality by providing controls concerning "access to various parts of the medical records, creating an audit trail and date/time stamping each entry or viewing, all of which is required by HIPAA regulations." Plus, effective April 20, HIPAA's new security rule will require increased security measures to protect all electronically stored data, from EMRs to emails, including: "computer firewalls, restricting transmission of EMRs via the Internet, virus scans, encryption technologies, password management, user audits and automatic log-offs."

Proponents of EMR systems believe that the systems may ultimately help reduce provider liability and insurance costs, by up to 20%, through reducing errors and ensuring compliance. Although they may eventually be economically beneficial, currently their cost, tens of thousands of dollars, serves to highlight the disconnect between wealthy large practices and health care facilities and the less-wealthy small or medium practices. Many physicians are waiting until a system is $10,000 or less per physician, is proven to save time and money, or that a law mandates that they have such a system, before purchasing one.

Aside from economics, other negatives primarily focus on the available technology. Physicians cite various reasons to wait on implementing an EMR system, including slowness of available computers, wasted time in data entry, and technology error. One 2-year examination of an order entry system in a Florida hospital showed, from 1997-2004, 45% of the errors were caused by the technology itself, resulting from "the lack of connectivity between it and other departmental information systems in the hospital."

Outside the hospital, physicians also may be unable to communicate if they have purchased their EMR systems from different vendors; currently there are 70. Physicians also complain about frustration with system limits, because some systems refuse to recognize even sight misspellings for medications and others made routine instructions such as ordering "clear liquids and advance diet as tolerated" impossible. Finally, they complained about the automatic alerts that pop up during entering of fairly basic decisions, saying that "although these alerts are designed to catch errors before they occur, the alerts became an unending series of questions, reminders and requests."

- *Amy Vandenbroucke*

> ***The system "would lead to fewer dangerous medical mistakes, reduce costs and improve care."***

Healthcare Disparities: *Meaningful Access to Care Demands Reimbursement for Provided Language Services*

Today, more than 28 million Americans are foreign born. Nearly 47 million people, or about 18% of the US population, speak a language other than English at home and some states have percentages significantly greater than the national average. Current figures indicate that as much as 8% of the population have identified themselves as speaking English "not well." Problems arise when these people access medical care. Communication is a physician's best diagnostic tool. Without proper dialogue, and in the absence of a translator, the healthcare encounter is compromised. Language barriers have also been shown to affect many healthcare variables including: follow-up compliance, adherence with medication regimens, appointment attendance, satisfaction with services, trust in providers, and are reflected in how minority patients perceive their healthcare encounter. Thus, without accurate communication, patients are denied *meaningful* access to quality care.

Because language assistance services are expensive, many physicians believe they can diagnose through non-verbal gesturing or fragmented communication in two languages. Unfortunately, sometimes this has led to misdiagnoses which had serious health consequences to patients, including on rare occasions, death. There is, in these instances, recourse in tort; however because there is no specific tort for failure to provide interpreters, this fix attempts to demand compliance through far of vicarious liability for improper medical care or lack of informed consent. Federal laws, such as Title VI of The Civil Rights Act, have had more success by requiring federal funds recipients to provide interpreters.

However, private physicians are outside the reach of Title VI because they receive Medicare Part B reimbursement which has never been considered federal funding. And, because the DHHS has placed increasing demands on federal funding recipients, which has resulted in financial strain for many small physician practices, many physicians have chosen not to participate in Medicaid programs. Ironically, the HHS policy guidelines which were intended to ensure language services have created an access problem for the very people they were designed to aid.

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Case Note: *Willis v. Wu*, 362 S.C. 146, 607 S.E.2d 63 (2004)

The Supreme Court of South Carolina was presented with issue of whether South Carolina recognized a common law cause of action for "wrongful life" brought by or on behalf of a child born with a congenital defect. The circuit court granted the physician defendant's motion for summary judgment stating that South Carolina does not recognize such claims. The Supreme Court affirmed the circuit court's finding that the tort of wrongful life is not recognized in the State of South Carolina.

The plaintiff ("Mother"), as guardian ad litem for her minor son ("Son"), brought a "wrongful life" action on behalf of Son against Mother's physician. Son alleged that the physician failed to adequately and timely diagnose his condition by prenatal testing and inform Mother of the results. According to Son, the interaction of the physician denied Mother the opportunity to decide whether to terminate the pregnancy while she was legally allowed to do so. Specifically, Son alleged that the physician was negligent in failing to timely perform or understand the significance of the ultrasound examinations. According to Son, the ultrasound examinations indicated the presence of hydrocephalus in the fetus, which is a congenital defect that caused Son severe consequences.

The Court declined to recognize the wrongful life action. The Court stated, the "contention of wrongful life plaintiffs is not that they should not have been born without defects, but rather, that they should not have been born at all. The essence of such claims is that the child's very life is 'wrongful.'" The Court reasoned that "….our culture is the precept that life is precious" and " …..therefore, our laws have as their driving force the purpose of protecting, preserving and improving the quality of human existence." The Court further reasoned that recognizing a wrongful life tort "would do violence to that purpose and is completely contradictory to the belief that life is precious."

- Shannon Verner

Case Note: *McDonald's Settlement*

A lawsuit was filed by a San Francisco area activist and attorney, Stephen Joseph, on behalf of BanTransFat.com and Katherine Fettke, against McDonald's over complaints that the company did not properly inform the public about delays in the plan to lessen the trans fat in its cooking oils. He had been seeking to raise public awareness to the health dangers caused by trans fatty acids (TFA), beginning by starting the website called BanTransFats.com. McDonald's announced in 2002 that it was changing to cooking oil with less TFAs, and the change would be complete by February 2003. McDonald's ran into operational issues and the oil was not changed, but plaintiffs claimed it did not effectively inform the public of this.

TFAs are found in hydrogenated or partially hydrogenated oils, which are used in thousands of processed food products like French fries, cookies, margarine, and cereals. TFAs are created when processing vegetable oils and have been found to be unhealthy as pure cholesterol. On January 12, 2005, the US Department of Health and Human Services (HHS) issues the *Dietary Guidelines for Americans 2005* ("*Guidelines*"), which included a recommendation that people "consume 10 percent of calories from saturated fatty acids and less than 300 mg/day of cholesterol, and keep trans fatty acid consumption as low as possible." The *Guidelines* also suggested that "the food industry has an important role in decreasing trans fatty acid content of the food supply." BanTransFat.com had also sued Kraft for the TFAs in oreos. Kraft responded by introducing three new varieties on oreos, a New, Improved Reduced Fat Oreo, Golden Oreo Original, and Golden Uh Oh! Oreo, without TFAs on April 6, 2004

McDonald's settled the TFA lawsuit on February 11, 2005. The settlement requires McDonald's to give effective notice to the public that the oil was not changed. Additionally, McDonald's will donate $7 million to the American Heart Association (AHA) to be used for the following: public education regarding trans fat; encouraging substitution of partially hydrogenated oils by the food industry; holding conferences on health issues associated with trans fat and the substitution of partially hydrogenated oils; and other activities regarding the impact of trans fat on public health. McDonald's must also spend $1.5 million on notifying the public about the status of its TFA initiative, with any extraneous amount donated to the AHA. McDonald's will also pay BanTransFat.com and Fettke each $7,500, along with paying the legal fees and costs for them to bring the lawsuits.

- Dayna Vidas

Case Note: *Planned Parenthood of Northern New England v. Heed*, 390 F.3d 53 (2004)

The United States Court of Appeals for the First Circuit, in *Planned Parenthood of Northern New England v. Heed*, 390 F.3d 53 (2004), affirmed the District Court for the District of New Hampshire's declaration that New Hampshire's law that requires minors to obtain parental consent before having an abortion was unconstitutional. Specifically, the Court of Appeals ruled that the Parental Notification Prior to Abortion Act (hereinafter Act) lacked a necessary exception for preserving a pregnant women's health and that the necessary exception which permits abortion in order to save the life of the pregnant woman was too narrow.

The Act prohibited an unemancipated minor from obtaining an abortion until at least 48 hours after written notice of the upcoming abortion had been delivered to the minor's parent in accordance with the Act's provisions. Notice was not required if an abortion provider certified that the abortion is necessary to prevent the minor's death and there is insufficient time to provide required notice. Furthermore, in order to avoid the notice requirements, a minor had a judicial bypass option available in which an abortion would be allowed if a judge determined that the pregnant minor is mature enough to provide informed consent or that the abortion without notification would be in her best interests. The Act provided for a court judgment within 7 calendar days after the petition is filed and an appellate ruling within 7 days of its docketing.

A number of abortion providers filed a civil rights complaint on behalf of pregnant minors requiring an abortion for health reasons seeking a declaratory judgment that the act is unconstitutional and a preliminary injunction to prevent its enforcement once it became effective. Violation of the Act could have resulted in criminal penalties, a misdemeanor, and was grounds for a civil action by a person denied notification. The District Court for the for the District of New Hampshire declared the Act unconstitutional, permanently enjoined its enforcement, and the Attorney General of the State of New Hampshire appealed.

Significantly, the First Circuit weighed in on the uneven, although enduring, Circuit split on the appropriate standard by which to evaluate facial challenges to the constitutionality of abortion statutes and regulations. The debate playing out among the Courts of Appeals is whether the Supreme Court's ruling in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), establishing what is known as the "undue burden" standard, replaces the general "no set of circumstances" standard established in *United States v. Salerno*, 481 U.S. 739 (1987) in evaluating facial challenges to abortion regulation. The Supreme Court recently utilized *Casey's* standard in *Stenberg v. Carhart*, 530 U.S. 914 (2000), which involved a partial birth abortion statute, but has never addressed its conflict with *Salerno's* standard, which had been used up until *Casey*.

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News of Interest: *Recent Studies on Maternal Homicide: Domestic Violence Implications*

Last month, the United States Centers for Disease Control and Prevention ("CDC") released a study with remarkably sad findings. The CDC discovered that thirty-one percent (31%) of "maternal injury deaths" are due to homicide. The leading causes of maternal homicide were found to be gunfire and stabbings, at fifty-seven (57) and eighteen (18) percent, respectively. Specifically, the study revealed that several groups were at a higher risk of homicide during pregnancy. African American women were seven times more likely to be killed during pregnancy than white women. The highest age group at risk was women younger than twenty (20). Also, unmarried women were found to be at a higher risk of maternal homicide than married women. Lastly, women receiving no prenatal care were at a higher risk than women who did receive such care.

Additional studies have come to similar conclusions regarding maternal homicide. A Maryland study reported in 2001 that homicide accounted for more than twenty percent (20%) of maternal deaths in that state. In 2003, Maryland also reported that African American teenagers were at the highest risk level for maternal homicide. Massachusetts discovered in 2002 that women between the ages of fifteen (15) and twenty-four (24) "were three times more likely to die of homicide during pregnancy and postpartum months than their older counterparts." Most public health officials define deaths as "associated" with pregnancy if they occur within twelve (12) months postpartum.

Researchers suggest that the numbers reported in current studies are much lower than the actual levels of maternal homicide. Following its year-long study of maternal homicide, The Washington Post revealed that the reason for under-reporting of maternal homicide is that "no reliable system is in place to track such cases." The Post reports that during homicide investigations, police agencies throughout the nation do not routinely inquire as to whether the woman murdered was pregnant.

Interwoven throughout the recent maternal homicide studies is the issue of domestic violence. Oftentimes, women who are killed during their pregnancy or postpartum months are victimized by their current or former intimate partners. It has been suggested that these present or past partners murder because they believe it is the last possible way for them to avoid being a father, getting married, paying child support or having their affairs revealed. In addition to maternal homicide, approximately four (4) to eight (8) percent of women are battered during their pregnancy.

The most important discovery from the recent studies discussed in this article is that the law surrounding domestic violence, specifically maternal homicide, needs to undergo massive improvements. Society must first develop comprehensive procedures for collecting maternal homicide data. Once it does so, society must then work to prevent maternal homicide and improve the law so that it protects pregnant women.

- Katy Sikich

Legislative Update: IL Health Care Justice

The Illinois General Assembly recently recognized the growing problem of the uninsured and underinsured residents of Illinois by enacting the Health Care Justice Act, 20 ILCS 4045 /1 et. seq. The Health Care Justice Act provides that by July 1, 2007, the State of Illinois shall implement a health care access plan that provides a full range of preventive, acute, and long-term health care services for state residents. This act was implemented on July 1, 2004 and required the creation of a Health Care Task Force within 30 days of its enactment to oversee the gathering of public input and to provide recommendations for a universal access health care plan.

The Task Force consists of 29 voting members appointed by the Governor, the President of the Senate, the Minority Leader of the Senate, the Speaker of the House, and the Minority Leader of the House. Additionally, the Directors of the Departments of: Public Health, Aging, Public Aid, Insurance, and Human Services or their designees shall be ex officio non-voting members.

The Task Force will seek public input on the development of a health care access plan by holding public hearings in each congressional district, beginning no later than January 1, 2005, and concluding on November 30, 2005. The Task Force will also consult with health care providers, health care consumers, and others to assist in the development of a health care access plan. Additionally, the Act mandates that the Department of Public Health, subject to appropriation or the availability of other funds, contract with an independent research entity experienced in assessing health care reforms, health care financing, and health care delivery models. This research entity will work directly with members of the Task Force to assess the different options and questions being debated.

The Task Force shall present a final report to the Governor and General Assembly no later than March 15, 2006. The report shall be based upon the public meetings and consultations and shall include a recommendation or recommendations on how the State of Illinois can provide access to a full range of preventative, acute, and long-term health care services to Illinois residents. The Act does not mandate the formulation of one particular plan, but rather creates a process to assess which plan or plans would work best for the State of Illinois. The Illinois General Assembly is encouraged to vote on the enactment of the plan created by the Task Force no later than December 31, 2006.

- Christopher Anderson

Legislative Update: Cheeseburger Laws

Cheeseburgers in Paradise? A question of utmost importance begs to be asked and answered: has our grand society finally yielded to the prophetic musings of Jimmy Buffet and granted cheeseburgers legal immunity? The answer to this seemingly silly question is: kind of, but not really. In recent years, several states have enacted so called “cheeseburger” bills, which grant fast-food restaurants and food manufacturers limited immunity against lawsuits from individuals who claim that their products resulted in their obesity.

Illinois, for example, enacted the *Illinois Commonsense Consumption Act* (745 ILCS 43; Illinois House Bill 3981) in 2004. The bill, which was co-sponsored by both Illinois Republican and Democrat lawmakers, is similar in scope to other state cheeseburger laws as well as the federal *Commonsense Consumption Act* (HR 339), which was enacted in 2004 by a 276-139 vote. As of March 1 of last year, nineteen states had either adopted cheeseburger laws or were considering them, including New Mexico’s *The Right to Eat Enchiladas Act*.

Supporters of these bills argue that the tide of frivolous lawsuits against food manufacturers and fast-food establishments will not make anyone thinner, that individuals must be responsible for their own eating habits, and that such lawsuits could ruin local and national economies. Opponents, however, counter that providing such immunity to the food industry will allow them to be irresponsible and that the food industry does not need such broad protection. Moreover, opponents are optimistic because at least 4 states voted against their own version of cheeseburger bills and fast-food restaurants are close to including nutrition labels on their products.

These legislative efforts are clearly related to the dismissal of the “McLawsuit” from federal court in 2003, in which the court cited a potential flood of similar cases as a primary reason for the dismissal. That being said, with the GOP enjoying majority status in both houses of Congress and in many states, I wonder if these bills aren’t riding the coat-tails of the Tort Reform movement. After all, no one is denying the fact that obesity is a serious health issue and that the number of obese individuals in our society is growing faster than our waistlines.

- Patrick McHale

Healthcare Disparities: *continued from page 2*

With Medicare and Medicaid budgets shrinking and the trend from private to public health insurance, alleviating this problem may seem daunting. But there are some steps we can take if all entities that have an interest in ensuring competent medical care share the responsibilities required to achieve this goal. First, since governments have an interest in assessing the language needs of their populations and already collect similar census data, sharing this information would eliminate the need to expend precious medical resources to retrace the government’s footsteps. This allows providers to focus of providing the best care possible. Second, current pilot programs have proven successful at developing affordable models that offer culturally and factually competent Spanish language services. The program has also had success partnering with local educational institutions to establish interpreter training programs. This could be used as a model to institute training programs for all identified language needs. And finally, states need to adopt reimbursement programs to offset the cost that providers currently absorb to provide language services. This also allows access to federal “matching” funds that have already been earmarked for these services.

- Sid Khanijou

OIG ADVISORY OPINIONS: Gainsharing Agreements between Hospitals and Physician Groups

To date, the Office of Inspector General ("OIG"), a division within the U.S. Department of Health and Human Services ("HHS"), has issued four advisory opinions in 2005, all of which permit proposed gainsharing agreements between hospitals and physician groups. To understand the significance of these opinions, some background is necessary.

An OIG advisory opinion is a legal opinion issued to parties upon formal request. The purpose of advisory opinions is to receive guidance about the application of the OIG's fraud and abuse authorities to the party's existing or proposed business arrangement. An OIG advisory opinion is legally binding on HHS and requesting parties. It is not binding on any other governmental department or agency. Favorable advisory opinions protect requesting parties from OIG administrative sanctions, so long as the arrangement at issue is conducted according to the facts submitted to OIG. However, no party can rely on an advisory opinion issued to another party.

Gainsharing agreements are arrangements in which hospitals offer physicians or a physician group a percentage of any reduction in hospital costs for patient care that is attributable to physician efforts. Most arrangements require that clinical care must not have been adversely affected as determined by selected quality and performance measures in order to receive payment. In addition, many agreements require a consultant's independent determination that the payment represents fair market value for the collective physician efforts. The purpose of gainsharing agreements is to align physician incentives with hospital goals of cost reduction. Physicians are not naturally concerned with hospital cost reduction because they are compensated (among other sources) by Medicare Part B and Medicaid, which do not apply the same cost-reduction pressures to physicians that Medicare Part A and the growth of managed care applies to hospitals.

In July 1999, OIG issued a Special Advisory Bulletin which stated that gainsharing agreements violate the Social Security Act based on the plain language of § 1128A(b)(1) and (2). The Act prohibits tying a physician's compensation for services rendered to reductions or limitations in items or services provided to Medicare or Medicaid patients who are under that physician's clinical care. In the bulletin, OIG stated three reasons why it would be inappropriate to protect individual gainsharing arrangements from OIG administrative sanctions through the issuance of favorable advisory opinions. Gainsharing agreements: (1) pose a high risk of abuse; (2) require ongoing oversight unavailable through the advisory opinion process; and (3) should be comprehensively and uniformly regulated rather than reviewed by OIG on a case-by-case basis through advisory opinions, which are an inadequate and inequitable substitute for regulation.

However, all four of OIG's advisory opinions issued between February 3 and February 17, 2005 stated that although the proposed arrangements violate the Social Security Act, OIG would refrain from sanctioning parties for performing their agreements because various factors were present in the proposed arrangements that would protect against patient and program abuse. In all four opinions, OIG used eight standardized criteria to weigh whether the gainsharing agreement at issue contained safeguards necessary to protect against abuse. The eight criteria can be reviewed in each of the four opinions found at http://www.oig.hhs.gov/fraud/advisoryopinions/opinions.html. The opinions also mention criteria that, if present in the proposed agreement, heighten the risk of abuse and thus, presumably heighten the risk of OIG sanctions if implemented.

Therefore, it appears that although OIG claims its 2005 advisory opinions are consistent with its 1999 Special Advisory Bulletin, there has been a fundamental shift in OIG's position regarding administrative sanctions of gainsharing agreements between hospitals and physician groups.

- Stacie Phillips

CASE NOTE: *Planned Parenthood of Northern New England*, *continued from page 4*

Although New Hampshire's Attorney General urged otherwise, the First Circuit unequivocally joined the Third, Sixth, Seventh, Eighth, Ninth, and Tenth Circuits in adopting *Casey's* undue burden standard. A statute poses an undue burden if in a large fraction of cases in which regulation is relevant it will operate as a substantial obstacle to a woman's choice to undergo an abortion. The Fourth and Fifth Circuits continue to use *Salerno's* no set of circumstances standard. A challenger of a statute under the no set of circumstances standard must establish that no set of circumstances exist under which the statute would be valid even if the statute may operate unconstitutionally under some conceivable set of circumstances.

Relying on *Casey* and *Stenberg*, the First Circuit ruled that regardless of the state's specific interest, the Constitution requires an exception for a women's health when an abortion restriction would place a women's health at risk, which the Act did not provide. It rejected the Attorney General's argument that the Supreme Court's upholding of a parental notification statute that contained no health exception in *Hodgson v. Minnesota*, 497 U.S. 417 (1990) controlled and that despite the lack of an explicit health exception, other provisions of New Hampshire law, including the judicial bypass provision, provide a functional equivalent. The Court ruled that the lack of a health exception was not challenged in *Hodgson* and, even if it was, *Casey* and *Stenberg* would require otherwise. Furthermore, the court ruled that the possible two-week delay of judicial bypass was not constitutionally sufficient.

Finally, given the way the death exception is drawn (abortion providers must certify that both an abortion is necessary to avoid the mother's death AND that there is insufficient time to provide notice), the First Circuit ruled the exception forces physicians into an unacceptable gamble. They must either risk the patient's death to comply with the 48 hour notice requirement or provide an abortion and face civil and criminal liability. Furthermore, the First Circuit found the lack of a specific scienter standard provided in the statute risked the application of a negligence standard, that provides for post hoc second guessing of good-faith medical assessments, would impermissibly chill a physician's willingness to provide lifesaving abortions and thus constitute an undue burden for minors in need of an abortion.

- Michael Woods

Symposium: **Disentangling Fact from Fiction** - *Continued from page 1*

The median household income for the area around Advocate Good Shepherd is $110,470 while at Bethany it is $22,426. The study indicated a clear disparity in investment between the two. "Between 1995 and 2003, Advocate spent $72 million on significant capital improvements at Advocate Good Shepherd, while spending nothing at Advocate Bethany Hospital."

The symposium continued with a series of three panel discussions. The first, "Learning from Tuskegee & Nazi Experimentation: Clinical Research & the New Genetic Divide", began with a discussion by Camille A. Nelson on the beginnings of unequal health treatment in our nation. Nelson, a faculty member at the Saint Louis University School of Law, described the medical experimentation performed on slave women by J. Marion Sims, often considered "the Father of Gynecology." At the time, the slave women were considered property; therefore, any consent to the procedures, which were performed without anesthesia, was given by the slaveholder. Also prevalent at the time was the practice of slave owners coercing slave women to have as many children as possible; a practice that marked the beginning of a system in which society's "privileged have an interest in the wombs of the marginalized." The panel continued with a discussion by Kevin Outterson, an associate professor of law at West Virginia University, on the need of reparations for those who have experienced substandard care because of their skin color or social status. Lisa Chiyemi Ikemoto continued the dialogue with a look at discourses about race in today's health care and research. Ikemoto explained the risk and social harm of the medical community pondering biological race, or the idea that racial differences are inherently biological. Fortunately, recent history shows that the medical community is beginning to discuss race in research in non-racist and unbiased terms. Michael Malinowski , a member of the American Bar Association President's Special Committee on Bioethics, ended the first panel with a discussion on how bio-banking, the process of collecting DNA and medical information from the general public, has the potential to include health care "have-nots" in the genomics revolution.

The second panel, "Confronting Barriers to Equitable Health Care," was moderated by Michele Goodwin, director of DePaul's Health Law Institute and Center for the Study of Race and Bioethics. Siddharth Khanijou, a second-year student at DePaul University College of Law, discussed the practice of providing interpreters when needed in medical care. Nanette Elster discussed the racial and ethnic disparities in the use of assisted reproductive technologies. Elster showed the increased risk of impaired fertility among African American women in today's health care system and the possibility of insurance companies including assisted reproductive technologies among their covered services in the future. Timothy Stoltzfus Jost followed up with a discussion of the role of Medicare in dealing with racial and ethnic disparities in health care, and Ruqaiijah Yearby displayed the prevalence of discriminatory health care in nursing homes. 40% of African Americans in nursing homes are in "poorly performing facilities" compared to only 7-9% of whites.

The symposium concluded with a third panel discussion: "Is Civil Rights Law Dead? Examining Regulatory Remedies to Eliminate Health Care Disparities." Dorothy A. Brown, well versed on the subject of social security, discussed the current disparities in today's social security system and the role the program can play in ending the imbalance of adequate health care. Brietta R. Clark, Professor of Law at Loyola University in Los Angeles, and Dayna Matthew, Professor of Law at the University of Colorado, discussed whether civil rights law is a viable weapon in the fight to eliminate disparities in the public health delivery system. Matthew also spoke about how civil rights law can be revived so that it sufficiently addresses the discrimination that is seemingly inherent in American health care. Finishing off the day, Emilie Junge, the community advocacy director of the Service Employees International Union (SEIU) Hospital, described her own personal campaign to build labor-community partnerships and the impending lawsuit to hold hospitals accountable to their patients, workers and the community at large. She hopes that her work in Illinois will begin to reform the overall health care system in the United States.

- Camilla Pollock

Session Highlight: **2005 ABA Health Law Section: Emerging Issues in Healthcare Law**

Overview of the CDC-ABA Partnership: The Community Public Health Legal Preparedness Initiative workshop brought together health care and public health attorneys to learn about legal preparedness during public health emergencies and natural disasters. A workshop director's guide is available. Planning committees in local communities are being established across the country.

Questions to ask your client: 1) Are you participating in the development, review or approval of plans as part of your ESF-8? 2) Do you have written patient transfer agreements with neighboring hospitals, trauma centers, skilled nursing units, outpatient facilities? 3) Are you certified in NIMS? Public health departments are given power by common law and most by state statute. Among these are the power to take over property, the power to quarantine, and the power to force evacuation. Health departments tell people to do/not do and go/not go. The private sector cannot ignore the possibility of a disaster. The disaster picks the locale not vice-versa. Some disasters afford a warning and others do not: tornadoes, earthquakes, plane crash, train derailment. Fundamental disaster problems include: 1) Emergency care systems receive a higher level of demand; 2) what happens to those health care delivery systems that need to be rerouted? Increasing caring capacities and shift to new delivery normals. Planning does not need to be by leaps and bounds in the event of an emergency instead it would produce a bell curve.

The ABA Health Law section offers ten (10) interest groups to participate in: eHealth Privacy & Security, Employee Benefits & Executive Compensation, Healthcare Facility Operations, Healthcare Fraud & Compliance, Healthcare Litigation & Risk Management, Managed Care & Insurance, Medical Research, Biotechnology & Clinical Ethical Issues, Payment & Reimbursement, Public Health & Policy, Tax & Accounting, and Transactional & Business Healthcare. This conference offers the opportunity to learn more about each interest group by attending lunchtime meetings and sponsored sessions. Members of each interest group include representatives from the private and public sector as well as higher education. For more information, please visit: http://www.abanet.org/health/home.html

- Carlota Toledo

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Monitoring the pulse of health law

Newsletter and sources available on the web!

www.law.depaul.edu/health

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NOTES FROM THE DIRECTOR

DePaul Health Law Institute and Seyfarth Shaw LLP

Recently Seyfarth Shaw LLP co-sponsored two of DePaul's Health Law Institute's symposium "Precious Commodities - The Supply And Demand Of Body Parts Treatment" on March 4, 2005 and "From Selma to Washington: Disentangling Fact From Fiction -- The Realities of Unequal Health Treatment" on March 5, 2005.

Seyfarth Shaw LLP has a national Health Care Practice representing hospitals, physician groups, pharmaceutical companies, biotechnology companies, long-term care and assisted living facilities, medical device manufacturers, and third party payors in a variety of health care matters, including, fraud and abuse, Stark, tax-exempt issues and general corporate issues.

For more information about Seyfarth Shaw's health law practice please contact Deborah Gordon, Chair Health Law Practice Group, at 312-781-8620 or dgordon@seyfarth.com.

For information about these symposia, please visit our website at: www.law.depaul.edu/health.

LETTER FROM THE EDITOR

This is the final issue of the first year of the Health Law Institute Newsletter. Volume One is complete, with many more to follow.

One of the primary goals of the Newsletter was to provide an avenue for health law students to learn and write about current topics and issues of interest in the vast realm of health law. Not only has this initial goal proven to be highly successful (with 12 student-writers who have submitted a piece for each issue), but the positive comments and feedback from across the country (and even abroad) is testament to the success of the newsletter's other primary goal, to monitor the pulse of health law.

The Newsletter strives to find the most recent cases, legislative changes, governmental reports, studies and news items relating to health law. Monitoring the significant changes impacting health issues has been a challenge, but we will continue to keep our fingers on the pulse!

Thank you for your support, suggestions and readership. See you next fall!

- Melissa Junge