



HEALTH LAW INSTITUTE NEWSLETTER

Monitoring the pulse of health law

SPRING COLLOQUIUM 2006

Please join us for our upcoming Spring Colloquium! Each month, scholars, judges, practitioners, and community leaders from around the country share their research and answer questions. For more information, please contact Michele Goodwin at (312) 362-5269.

Genetic and Medical Experimentation in the Aftermath of the Holocaust

Distinguished guest speaker, Patricia Heberer, will discuss Nazi human medical experimentation and the protocols derived in the aftermath.

Speaker: Patricia Heberer, Historian, U.S. Holocaust Museum

Date: January 25, 2006

Time: TBA

Location: TBA

Superbabies: The Use and Abuse of Children in Medical Testing

Date: February 15, 2006

Time: TBA

Location: TBA

Study Abroad: The Utilization of 3rd World Markets for Medical Experimentation

Date: March 15, 2006

Time: TBA

Location: TBA

Whose Agenda Matters Most?: Fiduciary Responsibilities of Physicians and Medical Professionals

Date: April 19, 2006

Time: TBA

Location: TBA

Hurricane Katrina's Public Health Silver Lining

By Ameer Lakhani

Hurricane Katrina may be the most devastating and expensive natural disaster in U.S. history. Yet, even Katrina may have a silver lining. Public health experts point to a phenomenon that has developed in the wake of Katrina. Katrina prompted the creation of free medical clinics for evacuees, thus expanding the country's public health care safety net for hundreds of thousands of uninsured Gulf Coast residents. As a result, those without money to seek health care have now received proper diagnoses and treatments. Many evacuees have received a week or month's worth of prescriptions, and local medical centers have devoted staff to shelters and evacuee assistance centers.

Surveys of a major health care center in Atlanta indicate health care workers have seen among the evacuees as many six cases per day of previously undiagnosed high blood pressure and as many as four cases per day of undetected diabetes. The benefits of these diagnoses extend beyond

the patients. By diagnosing patients early, it is possible to implement the use of medications and diet changes to prevent long-term complications. As a result, the number of costly emergency room visits may decrease nationwide, ultimately saving the U.S. health care system money.

Health care experts have noted, however, that although the doctors, hospitals, and pharmacies continue to provide free care to evacuees, the duration of this free care will be short-lived. Ultimately, government insurance programs need to expand to pay for these new patients. Before Hurricane Katrina, Congress discussed cutting \$10 billion from Medicaid. Federal officials now say they are working on finding ways to provide extra financial support for states that provide Medicaid to evacuees. Because of Katrina, many individuals have entered the country's health care safety net. Now the challenge is to find a way to provide services for these people for the long-term. □

Patients' Rights Prevail: Patient Safety and Quality Improvement Act Establishes Federal Protections

By Valerie Smith

On July 29, 2005, after a nearly two-year effort by the American Medical Association and its coalition partners, President George W. Bush signed the Patient Safety and Quality Improvement Act (the "Act") into law. The Act establishes federal protections that encourage the voluntary reporting of medical errors, the adverse effects of the errors and their underlying causes in an attempt to promote a culture of safety in health care.

The law creates a confidential reporting structure in which physicians, hospitals and other health care professionals and entities can voluntarily report information of error to a Patient Safety Organization

("PSO"). A PSO is an organization certified by the Secretary of Health and Human Services that conducts efforts to improve safety and the quality of health care through the collection and analysis of patient data. The Act requires the Secretary to maintain a patient safety network of databases that provides an interactive resource for PSOs and providers to develop voluntary national standards to promote the electronic exchange of health care information, and to contract with a research organization to study the impact of medical technologies and therapies on health care.

Continued on page 4

EDITOR'S NOTE

Dear Reader,

Welcome to volume two of the DePaul University College of Law Health Law Institute Newsletter! This year's newsletter staff is excited to present a new format we hope will be particularly reader-friendly. The first four pages of the newsletter will be devoted to general health law news. On page five, legislative updates will appear in their own discrete section. Finally, on pages six and seven, the case notes section will provide readers with recent court decisions on relevant health law.

Of course, each issue will continue to announce upcoming Health Law Institute events, lectures, and other activities, as well as faculty news and research.

As always, the newsletter will address a broad spectrum of health law issues transcending state, federal and international law. Further, the newsletter will continue to feature high quality stories written by health care practitioners and DePaul University College of Law students.

Thank you for joining us as we monitor the pulse of health law!

Lara Duda
Editor-in-Chief

HEALTH LAW NEWSLETTER

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DEPAUL UNIVERSITY
COLLEGE OF LAW

HEALTH LAW INSTITUTE NEWSLETTER

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Canada's Healthcare Crisis

By Amy Vandenbroucke

After the Supreme Court of Canada made a landmark decision in *Chaoulli v. Quebec* on June 9, 2005, the Canadian healthcare system has come under intense scrutiny. Until *Chaoulli*, the Canadian system, which provided free physician services paid for by taxes and privately financed purchases of core medical services, was illegal. However, in *Chaoulli*, the Court struck down a Quebec law banning the use of private insurance for medical procedures available under the province's universal healthcare system. In its 4-3 decision, the Court ruled that a lack of physicians and an increase in delays resulting from long waiting lists for surgical procedures have increased patients' risk of mortality or the risk their injuries are irreparable. While the decision takes effect immediately, the government of Quebec asked the Court for a two-year stay of the decision, in an attempt to prevent an upset of their current system. There was no immediate impact of the decision on the national system outside Quebec because the justices split evenly on the question of whether the Quebec law violated Canada's bill of rights.

This decision is a blow for Canadians, who are proud their healthcare system is based on an individual's need for care, rather than one's ability to pay for services. Overall, there is strong sentiment against the development of a private medical system. However, a recent survey suggests that Canadians have overlooked the reality of their healthcare system. In comparing healthcare system attributes, the survey showed that most Canadians rated their system higher than those of other industrial countries in a number of areas. Many Canadians ranked Canada in

the top thirteen of thirty countries in a number of Organization for Economic Cooperation and Development categories, such as access and public funding. In reality, Canada ranks 26th for access, a problem the Court recognized by pointing to ample evidence showing that access problems are widespread and, in serious cases, causing patient deaths. Additionally, studies have shown that wealthy and well connected individuals are able to seek more immediate care in the U.S., or the individuals use their influence to jump medical waiting lines. Further, Canada is ranked 21st in terms of the amount of public money, compared to private money, invested in the system. While the common misconception is that Canadian taxes pay entirely for the system, currently thirty percent of the system is privately financed.

Most legal experts believe *Chaoulli* will instigate comprehensive changes within the Canadian healthcare system. Specifically, experts anticipate an overhaul of the system to allow for more timely care, which is necessary to maintain the current universal healthcare program. Other provinces have already taken some initiatives. For many years, Alberta officials have suggested developing a private healthcare system, while the federal government has threatened to withhold financial aid to such programs. In Quebec, British Columbia and Ontario, private diagnostic and special surgery clinics have been appearing. Nonetheless, the country is divided, and Prime Minister Paul Martin has responded to such changes by reaffirming his government's commitment to strengthening the current public healthcare system. □

Soda Policy for Schools Targets Childhood Obesity

By Courtney Quilter

The American Beverage Association has introduced a new policy to curb the sale of soda in schools. The policy aims to address the problem of childhood obesity. Under the policy, Coca Cola and Pepsi will not sell regular or diet soda or sugary drinks in elementary schools. In middle schools, regular soda will only be sold after school hours. Many supporters of the new policy believe that it will cut down on middle school consumption because twenty-eight percent of choices in middle school vending machines are regular soda. After the new policy is implemented, there will be no choice of regular soda during the school day. In high schools, regular soda will not occupy more than fifty percent of vending machine selections. The American Beverage Association did not remove all regular soda from high school vending machines because it believed that high school students would make good, informed decisions. After the policy is implemented, Coca Cola and Pepsi will be replaced by healthier products, such as juice drinks, sports drinks, and iced tea.

The new policy has been met with criticism. Many critics see it as a marketing ploy and do not think it will change the

status quo or go far enough to restrict sales of unhealthy products. Others believe the policy falls short with regard to the high schools because many high school vending machines already meet the fifty percent requirement. A spokesman for Coca Cola indicated that purchases of regular and diet sodas are equal. Due to the equal purchases of regular and diet sodas, critics argue the status quo will not be affected by the new policy. Still others argue that some soda alternatives are not much better than soda because they are made with sugar syrups and salt, which nutritionists do not recommend for children. Finally, because the policy is voluntary and unenforceable, some elementary schools continue to sell soda even though Coca Cola and Pepsi have a policy against it.

Although the new policy has been met with criticism, Coca Cola spokesman John H. Downs, Jr. is optimistic about the success of the policy. Downs said, "We have been following the previous ban, but there are other bottlers that had a different point of view. Now the whole industry is behind it." □

NEWS OF INTEREST

Amendment of the Hospital Admissions Agreement: A Means to Deal with the Issues Raised by the State Charity-Care Litigation

By Sarah Mick

Litigation against the nonprofit healthcare sector began in 2004 when plaintiffs' attorneys brought a series of civil suits in federal district courts throughout the country. Plaintiffs alleged that defendant hospitals and hospital systems had breached implied contracts with the federal government to provide charity care in return for their tax-exempt status. Plaintiffs sued as wrongfully deprived intended third-party beneficiaries, but they were unsuccessful with this theory.

Then, in early February of 2005, plaintiffs' attorneys filed dozens of claims in state court opening up what they called a "second legal front" in nonprofit hospital litigation. These cases have raised new issues that may prove more serious. Plaintiffs have accused defendants of, for example, consumer fraud, deceptive and unfair business practices, unfair and predatory debt

collection practices, and usury. Plaintiffs have also claimed that hospitals engage in fraudulent, deceptive, or unfair practices by failing to disclose general pricing methods, practices of differential pricing, and the existence of charity-care programs.

Looking towards the future, an effective way hospitals can address these issues is to adopt amendments to admissions agreements. By adding a proposed unitary hospital "financial practices disclosure" section to admissions agreements, hospitals will be better protected from future failure-to-disclose types of claims, while enhancing contractual clarity regarding charges for services as well as effective communications with the public regarding billing and collection practices. Lastly, it may provide the added advantage that the statute of limitations will not begin to run until after the account has been closed. □

Rhetoric and Action Don't Align on Electronic Medical Records

By Adam Hitchcock

In President Bush's January 2004 State of the Union address he spoke of the importance of "computerizing medical records." The Administration went on the record as saying it wants most Americans to have an electronic medical record ("EMR") by 2014. Congress—with at least nine bills proposed addressing the issue—quickly joined the calls for an interoperable EMR network. The bill with the most fanfare and best chance to become law is the Wired for Health Care Quality Act (the "proposed Act"), which is a combination of two different bills and is sponsored by Senators Frist, Clinton, Enzi, and Kennedy.

The model EMR system, VistA, is currently used by the Veterans Health Administration. VistA has been developed over the past thirty years at a cost of several billion dollars. The proposed Act, on the other hand, would authorize a total of \$275 million in spending over the next two years, with spending "as necessary" from 2008 to 2010. VistA took thirty years and billions of dollars to get to where it is today and is currently operated solely within the Veterans Health Administration, representing a fraction of the U.S. population. In essence, the proposed Act is an attempt to develop a much larger version of VistA in one-third of the time and at a fraction of the cost.

Supporters of the proposed Act argue that the public

money allocated is in the form of matching grants, which means that the federal figure does not represent the entire funding for the project. Opponents of the proposed bill argued that, even with the matching grants, the budget for the Wired for Health Care model still falls far short of what most analysts have projected would be necessary to develop a national EMR system. For example, costs have been estimated to reach tens of billions of dollars.

Supporters of the proposed Act in Congress, as well as the President, have also argued that the extra funding would come from the private sector and that this money would merely jumpstart the project. The problem with this rationale is that the U.S. continues to be without an interoperable EMR system precisely because the private sector has been slow to invest in it. Not only has federal funding been insufficient to create a viable model, but the government has also failed to address the misalignment of incentives that block any significant EMR investment from the private sector. For example, physicians have no incentive to invest in EMRs because they would have to bear the costs while the benefits go to insurance companies and the government. This would be especially true of small practices, in which most of the country receives its health care treatment. □

Patients' Rights Prevail *continued from page one*

The Act amends the Public Health Service Act to designate patient safety data as privileged and confidential. The Act permits certain disclosures of patient safety data by a provider or PSO, including (1) voluntary information of error, (2) disclosures of data evidencing criminal acts that directly harm the patient, (3) information necessary for PSOs or other research organizations to perform data analysis, and (4) voluntary disclosures for public health surveillance.

The ultimate winners of the Act's passage are patients. The

legislation creates a balance between confidentiality for reporting error information and ensures accountability and appropriate penalties for unlawful disclosures. In addition, the Act preserves the confidentiality of patient information under the Health Insurance Portability and Accountability Act of 1996. Before the passage of the Act, patients reacted to errors by initiating law suits. Now patients have a forum for communication. Moreover, the new law encourages thorough examinations of the causes of health care errors and effective solutions to prevent recurrence. □

Illinois HIV Legislation

By Malcolm "Skip" Harsch

Governor Rod Blagojevich has signed a new bill passed by the Illinois legislature that promotes HIV prevention and increased HIV awareness among incarcerated African-Americans in Illinois. The bill, entitled the African-American HIV/AIDS Response Act, is championed by Representative Constance Howard, D-Chicago, and Senator Kimberly Lightford, D-Maywood, and is the first of its kind nationwide. The African-American HIV/AIDS Response Act (the "Act") will go into effect January 1, 2006.

The Act will expand the current HIV testing methods in both county jails and state prisons. The Act calls for the creation of four new government positions, including HIV/AIDS response officers in the Governor's office as well as in the state departments of health, human services and corrections. The Act requires all inmates, during intake, be provided with written information on HIV and AIDS as well as their option to be tested for HIV. The Act also entitles juvenile and adult inmates to participate in voluntary HIV counseling and testing with no co-pay. Further, the Act entitles inmates with HIV to medical care, counseling, and referrals to support services related to HIV. Finally, the Act provides that the Illinois Department of Corrections must offer inmates transitional case management, referrals, and support services upon being released.

The bill was proposed in response to the alarming increase in HIV/AIDS cases among African-Americans incarcerated in Illinois. While African-Americans account for only fifteen percent of the population in Illinois, they account for more than sixty-five percent of the Illinois prison population and more than fifty percent of all HIV/AIDS cases in the state. HIV infection rate among Illinois prisoners has risen to more than five times that of the general population in the state.

The Act also calls for the creation of a nine-member panel to review how well the prison system implements the new law. The panel will consist of two ex-offenders and representatives from three AIDS organizations. The law also provides for a university study to determine whether there is a correlation between incarceration and HIV infection. □

Illinois Tort Reform Laws

By Dayna Vidas

On August 25, 2005, Illinois Governor Rod Blagojevich signed Senate Bill 475 ("SB 475") to cap monetary awards for pain and suffering in tort cases. Senator James Clayborne, Jr. from East St. Louis and Representative Dan Reitz from Sparta sponsored the bill. SB 475 limits the damage amount a jury can award for non-economic, personal pain and suffering to \$500,000 from physicians and \$1,000,000 for hospital judgments. By establishing these award ceilings, the state is hopeful that insurance companies, self-insured health care providers, and physicians will be able to plan better for the monetary costs associated with malpractice awards and, in turn, decrease healthcare costs. In order to help reduce frivolous lawsuits, SB 475 also requires a doctor to certify that an action has merit before a case can be brought against either another physician or hospital. Additionally, SB 475 gives the state authority to aggressively regulate malpractice insurance companies' premium increases. In order to help enforce the new law, Blagojevich has sent a letter to all Illinois physicians asking about their malpractice premium rates.

SB 475 makes it possible for the state to deny medical malpractice rate increases. This will be enforced by eliminating the requirement that the business climate in Illinois be deemed "non-competitive." Additionally, the Department of Financial and Professional Regulation ("IDFPR") will collect and make available actuarial data relied upon for pricing by every medical malpractice insurer. Further, if a company files a request for medical malpractice rate increases of more than six percent, mandatory public hearings concerning the proposed increase will take place. If a company requests increases of less than six percent, the IDFPR has discretion to hold public hearings to determine whether or not these rate increases are justified.

The new law will also change the way physicians in Illinois are regulated and the way the Medical Practice Act is enforced. The law increases the statute of limitations from five to ten years for complaints and disciplinary actions against licensed doctors. As a result, the IDFPR will be able to prosecute cases to discipline doctors who have numerous simple negligence cases in which no single case rises to the level of gross negligence. SB 475 will also create an internet site where Illinois residents can learn about their doctors. The site will allow individuals access to background information about physicians, including data on the physician's previous five years' history of criminal convictions, malpractice awards, and disciplinary actions by Illinois or other states.

The new law reflects the state's need to decrease increasing costs of medical malpractice insurance. Blagojevich explained that his decision to sign the bill into law was based on Illinois' need to keep its doctors in Illinois so that health care will be accessible and affordable for all Illinois residents. The president of the Illinois State Medical Society, Craig A. Backs, M.D., thanked Blagojevich for recognizing the need for litigation reforms that will keep physicians in Illinois and preserve access to medical care for patients. This law was effective immediately on its signing, August 25, 2005. □

CASE NOTES

Carhart v. Gonzales, 413 F.3d 791 (8th Cir. 2005)

By Courtney Quilter

The United States Court of Appeals for the Eighth Circuit affirmed a district court's decision that the Partial-Birth Abortion Act ("Act") of 2003 was unconstitutional. The court concluded that because the Act failed to contain an exception for situations in which the procedure was necessary to preserve the health of the mother, the Act was unconstitutional.

Four physicians challenged the constitutionality of the Act of 2003 in an action against the Attorney General in the United States District Court for the District of Nebraska. The district court held that the Act was unconstitutional for two reasons. First, the district court found that Congress' finding regarding a medical consensus was unreasonable and, therefore, the Act was unconstitutional because it lacked a health exception. Second, the district court concluded that the Act imposed an undue burden on the right to an abortion since it covered the common late-

term abortion procedure.

The court of appeals agreed that the Act was unconstitutional. The court adopted a "substantial medical authority" standard in which a health exception is constitutionally required if a substantial medical authority supported the medical necessity of the procedure in some instances. If there was a lack of consensus in the medical community, the court reasoned the legislature should err on the side of protecting the mother's health and include a health exception. The court concluded that it was bound by a substantial medical authority standard that supported the medical necessity of a health exception because there was no consensus in the medical community regarding the safety, nor were there studies on the medical necessity of the procedure. Because the Act lacked a health exception, the court held that it was unconstitutional. □

Kobrin v. Bd. of Registration in Med., 832 N.E.2d 628 (Mass. 2005)

By Valerie Smith

A jury convicted psychiatrist Dr. Kobrin on two counts of Medicaid fraud. The Massachusetts Board of Registration in Medicine ("Board") subsequently revoked his medical license citing its authority to discipline a physician whose conduct undermined public confidence in the profession, as well as its duty to police the profession and discipline imposed on other physicians in similar circumstances. Kobrin sought an interlocutory appeal arguing *res judicata* prevented the Board from using the convictions as a basis to revoke his license.

The Massachusetts Supreme Judicial Court upheld the Board's decision to revoke Kobrin's license. The high court rejected Kobrin's contention that neither *res judicata* nor collateral estoppel precluded the Board's disciplinary action. The Board previously dismissed allegations that Kobrin was illegally prescribing drugs to patients and providing substandard psychiat-

ric care. The high court observed that neither claim preclusion nor issue preclusion barred the instant disciplinary action by the Board because the Medicaid fraud convictions were never at issue before. In addition, the Board can discipline Kobrin simply on the basis of the criminal convictions alone.

The high court concluded that the Board followed lawful standards. State law and due process afforded Kobrin the right to a hearing but recognized that the Board was not required to hold a hearing on the undisputed facts because Kobrin admitted to his conviction of Medicaid fraud. Kobrin's acknowledgement entitled the Board to revoke his license without holding a hearing. "No proof of actual harm to patients, or demonstration that the public has lost confidence in the medical profession, was necessary," said the court. The Board did not violate Kobrin's right to due process by revoking his medical license. □

Smith ex rel. Estate of Smith v. Botsford General Hosp., 419 F.3d 513 (6th Cir. 2005)

By Erin Wetherille

On August 18, 2005, the United States Court of Appeals for the Sixth Circuit reversed a trial court decision not to apply a Michigan state damages cap to a non-economic damages award. The representative of decedent's estate filed a suit against Botsford General Hospital for violating the Emergency Medical Treatment and Active Labor Act ("EMTALA") when it failed to stabilize the decedent, Kelly Smith, before transporting him. Smith had fractured his left leg during a rollover car accident. He was transported to Botsford, where he was diagnosed as having an open left femur fracture. Smith weighed approximately 600 pounds, and Botsford transferred Smith to another hospital due to its limited capacity to care for someone of his size. While in the ambulance, Smith's condition deteriorated and he died from extensive blood loss.

The jury ruled for the plaintiff and awarded \$35,000 for economic damages and \$5,000,000 for non-economic damages. Bost-

ford filed several post-trial motions for a new trial or an award reduction, but the district court denied them and Botsford appealed. The Sixth Circuit affirmed the lower court decision to strike testimony of an expert, but reversed the non-economic damages.

Plaintiff contended that EMTALA does not incorporate state law damages' caps under any circumstances, but the court rejected that argument. The court reasoned that the plain language of the EMTALA does allow for incorporation, and the majority of courts have found that its incorporation of state law extends to damages caps.

The plaintiff's failure-to-stabilize claim also constituted a malpractice action because it occurred within a professional relationship and raised a question of medical judgment. Because this was a valid malpractice claim and EMTALA can incorporate state laws, the state's \$359,000 non-economic damages cap applied to the plaintiff's award. □

Ferdon v. Wis. Patients Comp. Fund, 691 N.W.2d 353 (Wis. 2004)

By Erin Wetherille

Petitioner Matthew Ferdon sustained injuries at birth, referred to as obstetric brachial plexus palsy, resulting in a partially paralyzed and deformed right arm. The jury awarded Ferdon \$700,000 in non-economic damages and \$403,000 for future medical expenses. In accordance with Wisconsin Statutes § 655.017 and § 893.55(4)(d), the trial court reduced the damage award to \$410,322 for non-economic damages and ordered that all but \$100,000 of economic damages be placed into a medical expense fund.

The Wisconsin Supreme Court heard the case on appeal and applied the rational basis test to determine whether the state's \$350,000 cap on non-economic damages for medical malpractice actions, adjusted for inflation, violated the equal protection clause of Wisconsin's Constitution. The court determined the primary objective in enacting the statute was to ensure quality health care for the citizens of Wisconsin. The court relied on

five objectives in finding no justification for the cap. The court held the cap was not rationally related to the legislative objectives of (1) compensating victims fairly, (2) lowering medical malpractice insurance premiums, (3) keeping the Wisconsin Patients Compensation Fund's annual assessments to health care providers low, (4) lowering overall health care costs for consumers, or (5) ensuring quality health care by creating an environment that health care providers are likely to stay in or move to.

The cap was enacted in 1995, and many argue that it is one of the main reasons insurance premiums for Wisconsin physicians have remained lower in recent years than those in other states. The Court reasoned that the Patients Compensation Fund, which pays for medical liability claims that exceed a physician's personal liability, has flourished with or without a cap and studies indicate that caps on non-economic damages do not affect physicians' migration. □

Murfreesboro Medical Clinic, P.A. v. Udom, 166 S.W.3d 674 (Tenn. 2005)

By Hillary Ahle

Petitioner, a private medical practice in Tennessee, brought suit to enforce a covenant not to compete against a former employee, Dr. Udom. The covenant would restrict Dr. Udom from practicing medicine within a twenty-five-mile radius of Murfreesboro, Tennessee, for eighteen months after termination.

After both lower courts found the covenant not to compete was indeed enforceable, the Supreme Court of Tennessee recently reversed and held that non-compete covenants were unenforceable against physicians except in two scenarios: (1) when the employer in question is a hospital or an affiliate of a hospital, and (2) when the employer is a "faculty practice plan" associated with a medical school. When one of these scenarios is met, additional considerations remain, such as the reasonableness of the restrictions, the importance of the business interest at stake, and the resulting hardship placed on the physician.

The Court cited public policy as the central reason for its holding. Among the public policy concerns enumerated were the right to freedom of choice in physicians, the right to continue

an on-going relationship with a physician, and the benefits of having multiple physicians practicing in any given community. Additionally, the Court likened the medical profession to the legal profession in that both involve important fiduciary relationships between practitioner and client. This was significant in the holding because non-compete covenants are unenforceable within the legal profession. In support of this point, the Court acknowledged the American Medical Association's disfavor of covenants not to compete as an ethical standard for the profession to follow.

Finally, the Court pointed to a statute enacted by Tennessee's legislature that does not prohibit non-compete covenants as applied to physicians, but rather specifically allows them in the two aforementioned circumstances. Thus, the Court interpreted this statute to preclude the use of covenants not to compete in all other situations involving physicians, even though—as the dissent aptly reasons—this was not necessarily the intent of the legislature. □

Ernst v. Merck & Co. (Tenn. 2005)

By Malcolm "Skip" Harsch

On August 19, 2005, a Texas jury found pharmaceutical giant Merck & Co. liable for the death of a man who took the painkiller Vioxx. Plaintiff Carol Ernst won her lawsuit against Merck in Texas Superior Court in Angleton. Ernst contended the drug was responsible for the death of her husband, Robert Ernst. Robert, 59 at the time of his death, was a marathon runner, aerobics teacher, and Wal-Mart employee. He took the drug for arthritis up to and before the time of his death, caused by a heart attack. The jury awarded Ernst more than \$250 mil-

lion for mental anguish and punitive damages. Although Texas law will reduce the amount recoverable by Ernst, the verdict creates persuasive authority.

Merck pulled Vioxx from the market in September 2004 when a long-term study showed it could double the risk of heart attack or stroke if taken for eighteen months or longer. Merck says it will appeal the decision of the Texas jury on the basis of unqualified expert testimony. Merck attorneys claim the plaintiff's attorneys failed to meet their burden of proof. □



HEALTH LAW INSTITUTE NEWSLETTER

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ANNOUNCEMENTS

The DEPAUL JOURNAL OF HEALTH CARE LAW
presents its annual Symposium

*The Forefront of Biotechnology & Public Health:
Shaping a New Direction for the Debate of Morals in Medicine*

Friday, March 10 and Saturday, March 11, 2006
DePaul University, Lincoln Park Campus

The Symposium will provide a forum for debate on issues such as Assisted Reproductive Technology, Stem Cell Research, and Pharmaceutical Markets. In addition to these plenary sessions, the DePaul Journal of Health Care Law would like to invite scholars, professionals, and students to speak in an open forum of discussion on current health law issues. Interested speakers should contact Anne Brown at (312) 362-5634 or abrown25@students.depaul.edu