



HEALTH LAW INSTITUTE NEWSLETTER

Monitoring the pulse of health law

SPRING COLLOQUIUM 2006

Please join us for the Health Law Institute's Spring Colloquium! Each month, scholars, judges, practitioners, and community leaders from around the country share their research and answer questions.

Lectures generally take place during the lunch hour, providing law students with the opportunity to participate. For more information, please contact Rhea Banks at (312) 362-7271 or rbanks2@depaul.edu

Genetic and Medical Experimentation in the Aftermath of the Holocaust

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

Date: January 25, 2006

Time: 12:00 p.m. — 1:00 p.m.

Location: DePaul Center, Room 8005

Lessons from the Holocaust: Law, Biotechnology, and the Future of Medicine

Speaker: Judith Daar, Professor of Law, Whittier Law School

Date: February 15, 2006

Time: 12:00 p.m. — 1:00 p.m.

Location: DePaul Center, Room 8005

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

Speaker: Michele Goodwin, Professor of Law, DePaul University College of Law

Date: March 15, 2006

Time: 12:00 p.m. — 1:00 p.m.

Location: DePaul Center, Room 8005

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

Date: April 19, 2006

Time: 12:00 p.m. — 1:00 p.m.

Location: DePaul Center, Room 8005

FDA Issues New Rules for Drug Labels

By Ameer Lakhani

The Food and Drug Administration ("FDA") blames confusing medical information for the estimated 300,000 preventable causes of death or injury that occur each year in the nation's hospitals. As a result, the FDA is implementing new package inserts for all prescription drugs. The goal is to improve current inserts, which are printed in small text and contain confusing information. "Americans are overwhelmed with the complexity of health information," Surgeon General Dr. Richard Carmona said in a statement. "We have hit a point of information overload and the public health message is being diluted. This is of great concern when it comes to making sure a patient knows how to use prescription drugs safely and effectively," he added.

The new rules will effectuate changes to prescription drug labels that will result in the removal of the legal warnings and diagrams, and will provide more easy-to-read information. Among the changes is a box of "highlights" that will clearly state the most important information about a drug's risks and benefits. The new labeling information will also include a table of contents. Other information that will be on the new drug labels

includes the date on which the drug received U.S. approval; recent major changes to information about the drug; a toll-free number for patients and doctors to report suspected side effects to the FDA; drug interaction information; and a section that prompts doctors on the key factors they should relay to patients.

The revised labels will be more concise; however, FDA officials hope the reduced warning information will have more of an impact. The reduction in warning information initiated concern among pharmaceutical companies that have expressed fears that these new labels will make them susceptible to greater liability. In order to alleviate that fear, the FDA has stated that federally approved drug labels pre-empt state liability laws. This has upset some state officials. "This attempt to insert pre-emption language is a thinly veiled attempt on the part of the FDA to confer upon itself authority it does not have by statute and does not have by way of judicial ruling," said Steve Rauschenberger, President of the National Conference of State Legislatures. The new changes will be effectuated over the next seven years. □

CMS Announces Plan to Reimburse States that Cover the Costs of Dual Eligibles

By Erin Wetherille

The federal Medicare Part D program went into effect across the country on January 1, 2006. One problem in the implementation of the program involves dual eligibles, those Medicaid beneficiaries transitioning to Medicare [1]. Many have experienced problems getting the prescription drugs they need through the Part D program, and more than twenty-five states have been covering the costs of those prescrip-

tions to the dual eligibles under their state Medicaid reimbursement plans [2]. Since these dual eligible beneficiaries' prescriptions should be paid for by prescription drug plans, Centers for Medicare & Medicaid Services ("CMS") and the United States Department of Health & Human Services ("HHS") announced a plan on January 25 to reimburse the states for those costs.

Continued on page 4

The Cost of Virginity: Virginity Tests and Hymen Reconstruction

By Kari Kammel

Among Middle Eastern and Southeast Asian women, one current trend in plastic surgery is the reconstruction of the hymen, a procedure known as hymenoplasty or hymenorraphy. The surgery has become overwhelmingly popular in countries such as Egypt and Lebanon and among immigrant populations in the U.S. and Canada. Although some people initially mistake the surgery for a version of female genital mutilation, the procedure is not a mutilation, but a "ritualistic surgery" that gives the appearance of virginity [1]. Hymens can be broken through a wide range of activities including athletics, use of feminine products, injuries, sexual intercourse, and even pelvic exams [2]. Additionally, while some women are born without intact hymens, others have hymens that will not tear or bleed [3].

In Middle Eastern and South Asian communities, the belief that all virgins will bleed on their wedding night is still prevalent. Unfortunately, women whose hymens are not intact or who do not bleed on their wedding night often face punishments including death, divorce, annulment, assault, arrest, and/or disownment from family. Often a bride's family members, sometimes older women or fathers, check to see if the woman is a virgin before the consummation of the marriage. These "virginity tests" are performed throughout the Middle East, as well as in European countries [4]. In Turkey, for example, virginity tests are a government-sponsored activity, although the tests have been highly condemned by the Human Rights Watch [5]. Further, virginity tests have been requested in the U.S. by families that want proof of a woman's virginity.

Unmarried women throughout the Middle East and South East Asia are seeking hymen reconstruction for what they consider is a small price to pay compared to the punishment and stigma they potentially face without the procedure. In most Middle Eastern countries, hymen reconstructions are illegal; nevertheless, doctors perform the surgeries starting at \$50USD. In the U.S., the procedure costs a minimum of \$1,000.

For women who choose hymen reconstruction, the pressure of society is often so great that they feel as if they have no other option. For some women who have chosen to become sexually active, the surgery gives them the freedom to do so while also being able to meet their culture's traditional expectations. Additionally, the surgery allows women who have been victims of sexual violence to escape honor killings and restore family honor. Still, other women are simply afraid of not being able to

produce a "bloody sheet" on their wedding night.

Doctors around the world have raised ethical concerns as to whether these tests are consistent with bio-ethical principles and whether the procedure violates a woman's right to privacy [6]. Doctors in the Middle East have publicly condemned the illegal procedure because it violates religious laws and societal norms, yet many continue to practice the procedure [7]. In Europe, the procedure is deemed plastic surgery, and doctors generally support a woman's choice to have the procedure. As the procedure gains popularity in the U.S., more and more doctors will undoubtedly face the religious and societal issues surrounding the procedure. □

References

- [1] A. Logmans, A. Verhoeff, R. Bol Raap, F. Creighton, M. van Lent, *Ethical dilemma: Should doctors reconstruct the vaginal introitus of adolescent girls to mimic the virginal state? Who wants the procedure and why?* British Med. J. 316:459-460 (7 February 1998) (U.K.) available at <http://bmj.bmjournals.com/cgi/content/full/316/7129/459>; Sara Paterson-Brown, *Commentary: Education about the Hymen is needed - Ethical dilemma: Should doctors reconstruct the vaginal introitus of adolescent girls to mimic the virginal state? Who wants the procedure and why?* British Med. J. 316:459-460 (7 February 1998) (U.K.) available at http://www.findarticles.com/p/articles/mi_m0999/is_n7129_v316/ai_20334073; Dinesh Bhugra, *Commentary: promiscuity is acceptable only for men - Ethical Dilemma: Should Doctors Reconstruct the Vaginal Introitus of Adolescent Girls to Mimic the Virginal State?* British Med. J. 316:459-460 (7 February 1998) (U.K.) available at http://www.findarticles.com/p/articles/mi_m0999/is_n7129_v316/ai_20334072.
- [2] See generally, D.J. Rogers & M. Stark, *Letters: The Hymen is not Necessarily Torn after Sexual Intercourse* British Med. J. 317(7155):414 (8 August 1998) (U.K.) available at <http://bmj.bmjournals.com/cgi/content/full/317/7155/414>; see also, S.J. Emans, E.R. Woods, E.N. Allred, E. Grace, *Hymenal findings in adolescent women: impact of tampon use and consensual sexual activity*, 125(1) J PEDIATR. 153-160 (1994).
- [3] Sue Yeon Choi, *Restoring Virginity: Hymen repair surgery saves lives at the expense of deception*, BERKELEY MED. J. Fall 1998 available at <http://www.ocf.berkeley.edu/~issues/fall98/hymenrep.html>.
- [4] Xavier Bosch Barcelona, *Spanish doctors draw up advice on ethics of virginity certificates*, British Med. J. 324:996 (27 April 2002) available at <http://bmj.bmjournals.com/cgi/content/full/324/7344/996>.
- [5] *A Matter of Power: State Control of Women's Virginity in Turkey*, 6 Human Rights Watch 7 (June 1994); see also, Human Rights Watch, *Turkey: Virginity Tests Reinstated*, Human Rights Watch Letter to Bülent Ecevit, Prime Minister of Turkey, July 19, 2001, available at <http://www.hrw.org/press/2001/07/turkey0724-tr.htm>.
- [6] Barcelona, *supra* note 4.
- [7] See, Letter from Ihab Usta, M.D., Department of Obstetrics and Gynecology, American University of Beirut, Medical Center, Beirut, Lebanon, to Journal of Medical Ethics, *Hymenorraphy: what happens behind the gynecologist's closed door?*, 26 J. Med. Ethics 217-18 (2000).

Proposed Legislation May Rescind Measure Preserving Giveaways to Insurance Companies

By Kendra Gray

On January 24, 2006, Senator Hillary Rodham Clinton (D-NY) and Representative John Dingell (D-MI) announced they will introduce legislation in both chambers of Congress if the budget reconciliation bill is passed and signed by President Bush because the bill includes a massive giveaway to insurance companies. The Clinton-Dingell legislation would roll back a measure

preserving a loophole in Medicare payment policy that allows insurance companies to receive excess payments from Medicare. The Clinton-Dingell legislation would also eliminate a "slush fund" for insurance companies created in the Medicare Modernization Act.

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NEWS OF INTEREST

CMS Announces Plan *continued from page one*

Through the plan, the federal government will reimburse states for any differential between Part D reimbursement and the payment the states made, as well as for the administrative costs of facilitating the enrollment of dual eligibles into a prescription drug plan [3]. Before that difference is paid, the plan has guidelines for states to recover the Medicare value of the drugs the states paid for under Medicaid plans. The plan requires states to make progress toward using the Medicare Part D prescription drug system by February 15, 2006. CMS expected to have the issues with dual eligibles resolved by then.

Some lawmakers are concerned that this will be an unnecessarily slow process for the reimbursements to be paid. One plan for a quicker payment is a bipartisan bill introduced in the Senate on January 19. Under the bill, CMS would reimburse states by reducing the amount of money each state owes under the "clawback" provision of Medicare Part D, recover the payments from drug plans, and return that money to the Medicare Trust Fund [4]. Another bill, introduced on January 20 and backed by Democrats, would require CMS to have one full-time employee staffed with every State Health Insurance Assistance Program to aid implementation of Part D. In addition, the bill would mandate that drug plans provide new enrollees with a thirty-day supply

of medication during their transition to Part D and allow pharmacies to bill CMS directly for the costs of the transitional supply of medication [5].

On January 25, the Senate Finance Committee held a closed door meeting with HHS Secretary Michael Leavitt and CMS Chief Mark McClellan to discuss Part D implementation. Committee Chair Chuck Grassley said that no legislation is needed to change Part D and that he soon expects to get an answer from CMS on a more specific timeline for state reimbursement [6]. □

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- [1] HHS Plan to Pay States for Interim Drug Coverage Shortfalls Raises Questions, *Inside CMS*, Jan. 26, 2006.
- [2] Lawmakers, Consumer Advocates Urge CMS to Up Efforts on Part D, *Inside CMS*, Jan. 26, 2006.
- [3] Implementing Medicare Drug Benefit- Part 3: Hearing before the Senate Special Aging Comm., 109th Cong. (2006) (statement of Mark B. McClellan, Administrator, Centers for Medicare/Medicaid Services).
- [4] Democrats Criticize CMS Plan to Reimburse States, Push Legislation, *Inside CMS*, Jan. 26, 2006.
- [5] *Id.*
- [6] Finance Committee to Hold Hearing with McClellan to Probe Part D Roll-Out, *Inside CMS*, January 26, 2006.

Public Perception of Quarantine *continued from page two*

The participants in the study were given a questionnaire that addressed the following issues: concern about becoming ill with an infectious disease, support for measures implemented to protect the public, preferences for where the quarantine would take place, support for measures to monitor compliance with the quarantine, concerns about quarantine, and preferred sources of information in the event of an epidemic.

The study indicated that a sizable percentage of the public in each country was opposed to compulsory quarantine. Participants expressed many concerns including fear of overcrowding, infection, and an inability to communicate with family members while in quarantine. Other fears included inadequate access to needed health care needs, financial hardship caused by time lost from work, and social stigma after being released from quarantine.

The study provided many recommendations for how a

country can prepare for a quarantine in order to decrease the public's anxiety and increase compliance. It emphasized that it is highly advisable to elicit the voluntary cooperation of the public. It also noted how important it is for public health authorities to plan in advance. The study recommended that authorities prepare trusted spokespeople to educate the public about the seriousness of a disease threat, the necessary steps to halt the spread of the disease, and the importance of compliance. Authorities should also set up systems to compensate people for time they lose from work and help them meet their basic daily needs. Additionally, clear communication plans should be set up in advance. □

This article was adapted from the following source: Robert J. Blendon, *Attitudes Toward the Use of Quarantine In a Public Health Emergency In Four Countries*, *Health Affairs: The Policy Journal of the Health Sphere*, January 26, 2006, available at <http://content.healthaffairs.org/cgi/content/full/hlthaff.25.w15/DC1>.

Clinton-Dingell Legislation *continued from page three*

The Senate version budget reconciliation bill would have eliminated the "slush fund" for insurance companies included in the Medicare Modernization Act, but the conference committee responsible for reconciling the House and Senate reconciliation bills kept it in. The "slush fund" provides \$10 billion over ten years to encourage Preferred Provider Organizations to participate in the Medicare program. The Medicare Payment Advisory Commission disapproved of this giveaway, calling it unnecessary and unwarranted.

Charles Grassley (R-IA), the Senate Finance Committee

Chairman, responded to the allegation, "[t]he characterization of the Deficit Reduction Act as a big handout to health plans is outrageous and inaccurate. The reality is that the Senate-passed bill included several provisions to end overpayments in Medicare, not only for health plans, but for other providers as well." □

References

- Senator Hillary Rodham Clinton, *Clinton and Dingell Announce Legislation to Rescind Republican Giveaway to Insurance Companies*, Statements & Releases (January 24, 2006), available at: <http://clinton.senate.gov/news/statements/details.cfm?id=250698&&>

Attorney General Proposes Two Bills to Affect Illinois Hospitals

By Hillary Ahle

On January 23, 2006, Illinois Attorney General Lisa Madigan proposed two bills aimed at improving the way hospitals operate in Illinois. The Tax-Exempt Hospital Responsibility Act ("H.B. 5000"), introduced by State Representative George Scully, will require tax-exempt hospitals to provide a specified amount of charity care each year in order to keep their tax-exempt status. The Hospital Fair Billing and Collection Practices Act ("H.B. 4999"), introduced by State Representative Karen May, is intended to prevent unfair hospital billing practices and aggressive collection tactics.

H.B. 5000 will mandate each tax-exempt hospital in Illinois to create a charity care policy that guarantees poor, uninsured individuals free or deeply discounted care. The bill demands each tax-exempt hospital to provide at least 8% of its annual operating costs in charity care in order to maintain its tax-exempt status. Uninsured patients whose family income is no greater than 150% of the federal poverty limit will be eligible for free care, and care for those with an income between 150% – 250% of the federal poverty limit will be discounted on a sliding scale. Discounts that hospitals currently provide as charity care are usually subtracted from the price a hospital charges for a procedure; however, Madigan's proposed discounts must be taken off of a hospital's costs. Further, if a patient that is eligible for charity care is sick enough to accumulate more than \$10,000 in hospital expenses in one year, any care over that amount will be provided free of charge.

H.B. 4999 will apply to all Illinois hospitals, not just those with tax-exempt status, and its purpose is to standardize hospitals' billing and collection processes. This bill mandates that all patients be given itemized hospital bills, which may, in some cases, be inches thick. Patients will have the right to question or challenge a bill through the mail, by calling a toll-free number or by meeting with a hospital representative, and while any portion of a bill is being contested by a patient the hospital will not be able to proceed with its billing and collection practices. Additionally, if a patient cannot pay the bill in full, he will be entitled to make reasonable installments.

The Illinois Hospital Association ("IHA") President, Ken Robbins, commented on the proposed bills in a public statement, "In their present form, the proposals could be a real threat to the well-being of many hospitals, which are already facing serious financial challenges." Among other complaints, the IHA argues that H.B. 5000 does not take into account the uncompensated care hospitals already provide when bills go unpaid. "One out of every three Illinois hospitals is losing money. . . [y]ou'd be pushing them closer to the edge," IHA spokesman Danny Chun said in a January 23, 2006 article by Lori Rackl of the *Chicago Sun Times*.

Constituents supporting these bills argue that charity care requirements and billing practices must be standardized, and this action by the Attorney General is overdue. □

Our Vulnerable Adults: There's Hope Yet!

By Patrice Perkins

Illinois Attorney General Lisa Madigan introduced House Bill 4785, *An Act to Protect Vulnerable Adults*. State Representatives James Brosnahan (D-Oak Lawn) and Lee Daniels (R-Elmhurst) and State Senator Edward Maloney (D-Chicago) co-sponsor the bill. The law would protect the residents of state-licensed nursing homes. Illinois would be only the third state to enact this type of legislation [1].

The legislation stems from investigations that reveal pervasive criminal acts in Illinois nursing homes. Prior to this legislation, there was no state mandate that nursing homes conduct criminal background checks of new residents. In fact, in July 2005, Madigan's office reported that state wide there were eighty-six registered sex offenders among residents in fifty-one facilities and eighty-six convicted felons among residents in fifty-six facilities. "The problem was that the facility [officials] didn't know the person had a criminal history and may in fact have put other residents in jeopardy. They couldn't make an informed decision," said Donna Ginther, legislative representative for AARP Illinois [2].

The legislation could substantially impact the well-being of a sizable population. Approximately 100,000 persons reside in state-licensed nursing homes in Illinois. Specifically, the legislation would mandate nursing homes to conduct background checks of all current residents within sixty days. Former felons or sex offenders must undergo a risk assessment conducted by the Illinois Department of Public Health ("IDPH"). IDPH will also provide individual recommendations to the nursing home.

Nursing homes would also be required to report all fatalities to the county coroner or medical examiner. The legislation reflects the state's interest in protecting vulnerable residents of state-licensed nursing homes. "They [coroner's investigations] are too late for the victim, but vital to protect those who are still living in nursing homes where mistreatment occurs and are frequently hidden from public view," says Alice Hedt, Executive Director of National Citizens' Coalition for Nursing Home Reform [3].

Critics are concerned that *An Act to Protect Vulnerable Adults* involves an excessive burden. There are some administrative concerns to be addressed: who will subsidize background checks; which facilities are equipped to care for residents with criminal backgrounds; and how will the police manage the sudden influx of background checks? [4].

Others commend Madigan's efforts to move in the right direction. Polly Poskin, Executive Director of Illinois Coalition Against Sexual Assault states, "We are thrilled that Attorney General Madigan has placed the safety and well being of nursing home residents above special interests." Wes Bledsoe, president of A Perfect Cause, added "With this law, nursing home residents will live in more safe and secure environments" [5].

Should the General Assembly pass this legislation, vulnerable adults throughout Illinois will experience more peaceful nights. □

References

- [1] Madigan, Lisa, *Madigan, Brosnahan, Maloney: New Legislation Would Protect Nursing Home Residents from Convicted Felons and Sex Offenders*, available at http://www.ag.state.il.us/pressroom/2006_01/20060124.html.
- [2] Hope, Leah, *Law Requires Background Checks on all Nursing Home Residents*, available at <http://abclocal.go.com/wls/stpry?section=News&id=3244446&ft>.
- [3] Madigan, *supra* note 1.
- [4] Hope, *supra* note 2.
- [5] Madison, *supra* note 1.

CASE NOTES

Gonzales v. Oregon, 126 S. Ct. 904 (2006)

By Amy Vandenbroucke

On January 17, 2006, in a 6-3 decision, the U.S. Supreme Court decided that U.S. Attorney General John Ashcroft had exceeded his authority under the Controlled Substances Act ("CSA") when he issued a directive in 2001 stating that physician-assisted suicide ("PAS") was not a "legitimate medical purpose" for which physicians could prescribe federally controlled drugs. In so deciding, the Court affirmed the Ninth Circuit's ruling and upheld the well-founded notion that the practice of medicine should be left to the states. The decision ended a twelve-year battle over the law, which was first approved by Oregon voters.

The decision does not end the debate over PAS. A major contention was whether the state or the U.S. Attorney General ("AG") had the authority to define "legitimate medical purpose" with respect to the controlled substances regulated by the CSA. In his dissent, Justice Scalia argued that the AG was entitled to defer-

ence in interpreting the phrase to enforce the CSA. The majority disagreed, noting that the CSA splits authority between the AG and Department of Health and Human Services Secretary and, therefore, the AG does not have unlimited authority. Furthermore, the states have traditionally held the right to make such determinations as relating to the practice of medicine. Although the Court resolved the issue for the moment in determining that the state, not the AG, had the authority to define "legitimate medical purpose," Congress may amend the CSA to specify that PAS is not a legitimate medical purpose for which physicians can prescribe federally regulated drugs.

As a result of this decision, Oregon physicians may continue prescribing life-ending drug doses to statutorily defined terminally ill patients under the state's Death with Dignity Act. The decision also clears the way for other states to pass similar legislation. □

Grove v. Northeast Ohio Nephrology Associates, Inc., 2005 WL 3537656 (Ohio App. 9th Dist.)

By Valerie Smith

The Ohio Court of Appeals reversed a lower court decision and held that the Health Insurance Portability and Accountability Act's ("HIPAA") preemption provision does not supersede the contrary Ohio law, R.C. 2317.02.

Plaintiff Marvin Grove and others sued Northeast Ohio Nephrology Associates, Inc. ("NONA") and Summit Renal Care L.L.C. ("SRC") alleging that appellants had a duty to assess patient Pleli's condition after treatment and prevent her from driving in an impaired state. The complaint further contended that, as a result of appellant's breach of duty, Pleli lost control of her automobile, hitting and injuring plaintiffs.

Plaintiffs requested access to Pleli's medical records, but SRC objected, asserting patient privilege. After the trial court conducted an *in camera* review of the records, the court allowed plaintiffs to receive information related to the treatment Pleli received while in the facility, but denied access to her records.

The Ohio Court of Appeals turned to the issue of physician-

patient privilege and found Pleli's treatment was protected by Ohio law R.C. 2317.02. The appellate court found that the trial court abused its discretion when it denied plaintiffs access to Pleli's records while simultaneously ordering that the appellants provide information regarding the treatment received by Pleli.

Plaintiffs next argued that HIPAA supersedes R.C. 2317.02, thus allowing for discovery of Pleli's medical records. In finding this argument unpersuasive, the appellate court stated that HIPAA contains an exception for state law that "relates to the privacy of individually identifiable health information." Thus, the appellate court found R.C. 2317.02 should prevail.

HIPAA contains a preemption provision, §160.203, but the Ohio law, 2317.02(B)(1), relates to the privacy of individually identifiable health information and is more stringent than HIPAA. Due to HIPAA's exception to preemption for a more stringent state law, the Ohio law stands. □

Pardo v. General Hosp. Corp., No. SJC-09433, 2006 WL 168373 (Mass. Jan. 26, 2006)

By Adam Hitchcock

On January 26, 2006, the Massachusetts Supreme Judicial Court ruled that in suing a hospital for alleged discrimination based on sexual orientation, the physician plaintiff was limited to discovery of documents that do not fall under the state's medical peer review privilege protection. The Court held that the plaintiff was not entitled to "the records of numerous other peer review proceedings that had nothing to do with the plaintiff." In doing so, the Court attempted to strike a balance between the state's interest in protecting its citizens against discrimination based on sexual orientation and the state's interest in eliminating conduct by a health care provider that may put patients at risk.

Plaintiff Francisco S. Pardo, a radiologist oncologist, who had been with the General Hospital Corporation since 1986, alleged that he had been discriminated against after he revealed to his de-

partment head, Dr. Herman D. Suit, both that he, Pardo, was homosexual and that his life partner was HIV positive. The hospital provided evidence that showed that Pardo's reduction in responsibilities did not occur until after Dr. Suit received several complaints from other doctors about Pardo's job performance.

The state legislature provides a narrow exception to the peer review privilege and, in this case, the Court held that Pardo had not met that exception. To qualify, a plaintiff must show "a member of a medical peer review committee did not act in good faith in connection with his activities as a member of the committee."

While recognizing the importance of comparative information in discrimination actions, the Court said the plaintiff did not provide evidence showing that Dr. Suit's decision was influenced by discriminatory animus rather than concern for patient care. □

C.N. v. Ridgewood Bd. of Education, 430 F.3d 159 (3d Cir. 2005)

By Dayna Vidas

In the fall of 1999, the Ridgewood School District of New Jersey administered a survey to students who were in seventh through twelfth grades to assess and meet the needs of the youth community. The survey asked students information about their drug use, alcohol use, sexual activity, physical violence experiences, suicide attempts, personal associations and relationships, and views on public interest matters. The survey was designed to be voluntary and anonymous and its results were released in the aggregate without any identifying information. Nonetheless, three students and their mothers brought an action against the Ridgewood Board of Education and several school administrators claiming the survey, as it was administered, was neither anonymous nor voluntary in violation of the students' rights under the Family Education Records Privacy Act ("FERPA"), the Protection of Pupil Rights Amendment ("PPRA"), and the First Amendment of the U. S. Constitution.

On December 1, 2005, the United States Court of Appeals for the Third Circuit held that the survey did not violate the students' right to privacy because it failed the five-factor balancing test. The Court also held that the evidence showed the survey was involuntary because teachers told the students they had to take the survey and one hundred percent of the students took the survey. Additionally, the Court did not find sufficient evidence supporting lack of anonymity because the surveys had no distinguishing marks to tie them to the students. Furthermore, the Court held that even though the evidence showed that the survey was involuntary, the survey did not violate the children's Constitutional right against compelled speech because children in public schools do not have the same First Amendment rights of adults in other settings. Thus, the Court affirmed the grant of summary judgment in favor of the Board of Education and school administrators. □

Ayotte v. Planned Parenthood of New England, 126 S.Ct. 961 (2006)

By Malcom "Skip" Harsch

Ayotte presented a facial challenge to the parental notification abortion law in New Hampshire. On January 18, 2006, the U. S. Supreme Court, in a unanimous decision, vacated the judgment of the First Circuit, holding that "invalidating the statute entirely is not always necessary or justified, for lower courts may be able to render narrower declaratory and injunctive relief."

In June 2003, the New Hampshire Congress passed HB 763-FN, the New Hampshire Parental Notification Prior to Abortion Act (the "Act"). The Act required parental notification before abortions could be performed on unemancipated minors. In November 2003, Planned Parenthood of New England filed a complaint seeking a declaratory judgment that the Act was unconstitutional and sought a preliminary injunction to prevent its enforcement once it became effective. The federal district court

found the Act was unconstitutional and issued a permanent injunction. The court held the law lacked an explicit exception to the notification requirement to protect the health of the pregnant minor, and the exception to the Act's notification requirement to prevent a minor's death was unconstitutionally narrow. The First Circuit unanimously upheld the district court's ruling.

The U. S. Supreme Court vacated the First Circuit's decision, holding that "states have the right to require parental involvement when a minor considers terminating her pregnancy." The Court also noted, "a state may not restrict access to abortions that are necessary. . .for preservation of the life or health of the mother." Finally, the Court's narrow ruling affects only the lack of a health exception in the case at hand. □

Poli v. Mountain Valley Health Ctrs., No. 2:05-2015-GEB-KJM, 2006 WL83378 (E.D. Cal. Jan. 11, 2006)

By Courtney Quilter

The U. S. District Court for the Eastern District of California dismissed a plaintiff's claim that defendant Rite Aid violated the Health Insurance Portability and Accountability Act ("HIPAA") when the pharmacy released the plaintiff's prescription records to his employer. The Court concluded that HIPAA does not expressly or implicitly provide for a private right of action. The Court denied Rite Aid's motion to dismiss plaintiff's negligence and invasion of privacy claims.

Plaintiff Poli worked for defendant Mountain Valley Health Center as a physician assistant and nurse practitioner. Throughout his employment, Poli often received prescription recommendations from doctors, which he transmitted to the pharmacy and had filled for personal use. At one point, Poli informed a doctor that he had been using Xanax. The doctor approved his use of the drug and Poli subsequently called Rite Aid and told the phar-

macist that a doctor recommended he continue using Xanax. Rite Aid gave him twenty pills. Later, Poli was stopped by the police and the prescription drugs were discovered in his car. Police conducted an investigation of where he had obtained the drugs during which they contacted Rite Aid and obtained his prescription records. Poli sued Rite Aid for violating public policy by failing to comply with HIPAA when it released his medical records.

The Court dismissed Poli's cause of action for violation of public policy with prejudice. The Court found that HIPAA does not expressly or implicitly provide for a cause of action. In reaching its holding, the Court relied on the specific delegation of authority to the Secretary of Health and Human Services to enforce HIPAA. Since there was no congressional intent to create a private right of action, Poli's violation of public policy claim failed. □



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Friday, March 31 & Saturday, April 1, 2006

DePaul University, the DePaul Center, 25 East Jackson Boulevard, Conference Room 8005

In 2005, the world witnessed the destructive force of Hurricane Katrina, devastating earthquakes in Pakistan, the cross transmission of bird flu to human populations in Turkey and China, and the real threat of bioterrorism. In each scenario, we see governments struggling in the aftermath to make sense of the devastation and human displacement. Medical teams, try as they might, are not always prepared and alerted as to how best to investigate and quickly render assistance. Researchers who can predict certain patterns and trends do not always have an open door to policy-makers. Addressing the global impact of these threats, both natural and man-made, costs hundreds of billions of dollars. Millions have been displaced and the collateral destruction is severe. What are we to do about it? What are the proper roles and responsibilities of government?

This symposium acknowledges the roles that wealth, cul-

ture, and social status may play in determining how communities survive and predict disasters. It will address the role of government, policy-makers, community organizations, the World Health Organization, and other key players in properly situating and providing relief to respond to these issues.

We invite you to participate in this conference. The organizers encourage broad and creative thinking and approaches to the subject presented. In attendance at the meeting will be government officials (state and federal), judges, doctors, nurses, professors, community activists, and students. The 2006 Health Law Institute Symposium is a summit, bringing together critical thinkers in the fields of law, religion, medicine, biotechnology, cultural studies, bioterrorism, and race.

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