

# LAW & HEALTH CARE

University of Maryland School of Law  
Spring 2009 Vol. XVI, No. 2



## THE INTERSECTION OF ADDICTION AND HEALTH LAW

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The cost to society of alcohol, tobacco, and other drug (ATOD) addiction is huge and unrelenting. These costs include the health care costs of ATOD-related illnesses; the costs of treating abuse and dependence; lost productivity of workers who abuse ATOD; premature death of ATOD users; costs involving the criminal justice system and social welfare administration; property losses from drug and alcohol-related motor vehicle crashes and fires; and the lost productivity of the victims of drug and alcohol-related crime and individuals imprisoned as a consequence of such crime. Statistics that quantify and demonstrate these costs are plentiful and alarming:

- The Office of National Drug Control Policy reported that in 2002 untreated substance abuse cost society \$181 billion, \$108 billion of which was associated with drug-related crime.<sup>1</sup>
- The National Highway Transportation Safety Administration's 2007 Annual Assessment of Motor Vehicle Traffic Crash Fatalities and Injuries showed that 31.7% of traffic fatalities were alcohol-related.<sup>2</sup>
- The National Bureau of Crime Statistics found that 30% of violent crimes involved an offender who had been drinking and two-thirds of victims who suffered violence by an intimate (a current or former spouse, boyfriend, or girlfriend) reported that alcohol had been a factor.<sup>3</sup>
- In 2004, the CDC found that the total annual public and private health care expenditure caused by smoking was \$96 billion, of which \$30.9 billion was federal and state government smoking-related Medicaid payments; \$27.4 billion comprised Medicare expenditures;

and \$9.6 billion accounted for other federal government tobacco-caused health care costs (e.g. through VA health care).<sup>4</sup>

- The CDC also estimated that, in 2004, annual health care expenditures solely from secondhand smoke exposure were \$4.98 billion.<sup>5</sup>

These statistics, particularly the costs to the health care system, demonstrate the importance of studying and understanding the role of the law in facilitating appropriate and sustainable solutions to the problem of misuse of alcohol, tobacco and other drugs. Several



(l to r:) Dr. David Lewis, Professor Richard Bonnie, and L&HCP Director Diane Hoffmann at Addiction Conference. See page 9 for details.

faculty members at the University of Maryland School of Law are bringing attention to legal issues relating to addiction through their scholarship and clinical work. In this issue of the newsletter, we look at how the law has treated addiction and addicts and current legal issues in prevention and treatment.

Addiction is a complicated topic to discuss because the various substances to which an individual can become addicted have differ-

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The Law & Health Care Newsletter is published twice a year by the Law & Health Care Program at the University of Maryland School of Law

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## Addiction and Health Law

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ent physiological affects; are regulated differently; and are subject to vastly different cultural attitudes. The most obvious regulatory difference between the different classes of addictive substances is that some are legal and some are not. Among those that are legal, i.e. alcohol, tobacco and prescription drugs, alcohol and tobacco are readily available to adults whereas prescription drugs are more difficult to procure. Moreover, there are varying degrees of stigma attached to specific addictions. In the case of alcohol, moderate consumption is widespread, culturally accepted and even thought to be healthful in certain circumstances, e.g., the promotion of red wine as a heart-healthy beverage. On the other hand, illegal drug use is widely reviled and the subject of great demonization by politicians and the media. Given the differences associated with various addictive substances, the regulatory and treatment strategies for each are quite different. Nonetheless, as a deeper understanding of the process of addiction has grown over the years, many experts group alcohol, tobacco and other drug addictions together in order to highlight the commonalities of these various addictions and even the relationship of one addiction to another.<sup>6</sup>

The first legal measures against drug abuse in the United States were aimed at opium use. These early measures did not target addicts or criminalize their behavior but rather were aimed at drug suppliers. In a recent article, Law & Health Care Program (L&HCP) Director Diane Hoffmann describes the history of drug control policy in the United States and notes that it was not until 1914, with the passage of the Harrison Narcotic Act,<sup>7</sup> that federal law addressed the issue of the non-medical use of narcotics.<sup>8</sup> The Act forbade the sale of substantial doses of opiates or cocaine except by licensed doctors and pharmacies. The Act effectively criminalized non-medically authorized possession of opiates and cocaine—the first time criminal sanctions were applied to what had previously been considered a purely medical matter.<sup>9</sup>

Although the Act permitted the sale of opiates for medical use, Federal drug agents opposed any form of narcotics distribution and harassed physicians who pursued narcotic treatment efforts. Many

physicians argued, however, that treating the “agonies of unrelieved addiction” was within their duties under the Hippocratic Oath.<sup>10</sup> Several Supreme Court opinions addressed the question of whether the Act allowed treatment or maintenance of addicts by physicians. Over a six-year period starting in 1916, the Court went from viewing the Act as allowing physicians to prescribe to addicts to stating that prescribing to an addict to keep him comfortable by maintaining his customary use was not in the course of professional treatment, to adopting a view that professional practice did not include medication for the purpose of curing an addict.<sup>11</sup> This final determination set the stage for practitioner investigations and prosecutions for years to come.

Over time, the approach taken by the Harrison Act—considering drug use a medical issue and limiting federal involvement in regulating drug use—was abandoned in favor of the current model which treats drug use as a punishable behavior and involves vast government oversight and regulation of drugs. Arnold Trebach, who has written extensively on U.S. drug policy, attributes this shift to the reluctance on the part of American doctors to fight for the right to make private medical judgments, as did their British counterparts.<sup>12</sup> Until recently, doctors in Britain could administer drugs (including morphine) to addicts, wean addicts with gradually diminishing doses of heroin, or maintain them on stable doses of inexpensive, pure heroin for the rest of their lives. The British approach has, at least until recent years, held addiction levels stable and largely removed the impetus for heroin-related crime. Instead, Trebach argues, most American doctors supported the efforts of Treasury officials who gradually regulated away most of the discretion the medical community had regarding



the use of narcotics. Others have argued that the Depression and WWII changed the way Americans viewed the role of government and this paved the way for the federal government to play a more active role in drug regulation.

In 1938, the Food, Drug and Cosmetic Act<sup>13</sup> was passed to give the government a greater role in oversight over the sale of drugs and, in 1962, on the heels of the thalidomide crisis, the Food and Drug Administration (FDA) was established. In 1965, amphetamines, barbiturates,

cornerstone of this system is the registration of all those authorized by the DEA to handle controlled substances.

It is widely acknowledged that the CSA brought about the nation's current approach to the problem of substance abuse. Instead of adhering to the medical model represented by the Harrison Act, the CSA placed drug use squarely in the individual behavioral realm with the government playing the role of enforcer.<sup>17</sup>

The CSA marked the beginning of what President Nixon called the "war on drugs."

sales, state monopolies on liquor sales, or hybrid blends of the two systems. Within the federal framework noted above, state and county liquor agencies exercise a broad range of powers over the conditions under which alcohol is advertised, sold, and consumed.

Similar to alcohol, tobacco is also regulated primarily through age-related purchasing restrictions and warning labels. There have been many unsuccessful attempts to bring tobacco under the control of the FDA, mostly recently via the Family Smoking Prevention and Tobacco Regulation Act that passed the House last summer but faced a veto threat from then-President George W. Bush and did not get a vote in the Senate. Rep. Henry Waxman recently reintroduced the bill. Currently the federal government minimally regulates tobacco via Surgeon General warnings, prohibition of television advertising, certain tar and nicotine disclosures, regulation of cross-border smuggling, and some agricultural safeguards. The federal government also requires states to meet certain targets for reductions in youth access to tobacco but the setting of an age restriction is purely a state issue. States and municipalities also regulate tobacco through a variety of rules relating to where and when tobacco products can be purchased and consumed.

Addiction continues to be a pervasive problem in the United States. Epidemiological data suggest that lifetime prevalence rates for substance abuse disorders among adults in the United States are 13.5% for alcohol dependence and abuse<sup>19</sup> and 6.1% for other drug dependence and abuse.<sup>20</sup> Rates of addiction are even higher among vulnerable populations such as the institutionalized, the incarcerated and the homeless. Drug addiction is one of the most common diseases in the United States. It is estimated that over nine million Americans need drug treatment, making addiction more prevalent than coronary heart disease and stroke and as prevalent as cancer.

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Managing Director, L&HCP*

<sup>1</sup> *The Economic Costs of Drug Abuse in the United States: 1992–2002*, Office of National Drug Control Policy, available at [http://www.whitehousedrugpolicy.gov/publications/economic\\_costs/further.pdf](http://www.whitehousedrugpolicy.gov/publications/economic_costs/further.pdf).

*It is widely acknowledged that the Controlled Substances Act (CSA) brought about the nation's current approach to the problem of substance abuse. Instead of adhering to the medical model represented by the Harrison Act, the CSA placed drug use squarely in the individual behavioral realm with the government playing the role of enforcer.*

and, three years later, LSD, were labeled as "dangerous drugs" and their use was completely banned by the Drug Abuse Control Amendments<sup>14</sup>—the first time the federal government completely banned the use of a drug, even by prescription from a physician.

In 1969, President Richard Nixon asked the Attorney General to prepare a comprehensive new measure to combat drug use and addiction at the federal level. In addition, Nixon established the National Commission on Marijuana and Drug Abuse to study marijuana abuse in the United States. The Commission recommended the decriminalization of marijuana in small amounts, noting that "[t]he criminal law is too harsh a tool to apply to personal possession even in the effort to discourage use . . . . The actual and potential harm of use of the drug is not great enough to justify intrusion by the criminal law into private behavior, a step which our society takes only 'with the greatest reluctance.'"<sup>15</sup>

The recommendations of the Commission were not followed and shortly thereafter, in 1970, Congress passed the Controlled Substances Act (CSA) which created the Drug Enforcement Agency.<sup>16</sup> The CSA classifies controlled substances into one of five schedules based on their potential for abuse, psychological or physiological dependence, and medical uses. Drugs in each Schedule are subject to different rules for prescribing and distribution. The CSA also creates a closed system of distribution for those authorized to handle controlled substances. The

In addition to federal control of substances considered drugs, the campaign has also included efforts on the part of the government, with the assistance of participating countries, to reduce the illegal international drug trade by curbing the production and distribution of drugs. Critics have noted that, for all the damage the campaign has done to our relations with drug-producing countries and on a generation of young black men who were incarcerated on drug charges, the drug war has likely been ineffective in stemming illegal drug use or addiction. In 2001, the National Research Council's Committee on Data and Research for Policy on Illegal Drugs published its findings on the efficacy of the drug war.<sup>18</sup> The Committee found that existing studies on the effectiveness of efforts to eliminate illegal drug use and smuggling have all been inconclusive.

While the government has criminalized possession and use of controlled substances without a doctor's prescription, since the country's failed attempt at prohibition of alcohol in the 1920s and early 30s, alcohol has primarily been regulated through minimum drinking ages and warning labels. The federal Alcoholic Beverage Labeling Act, enacted in 1988, requires the labels of alcoholic beverages to carry a warning notice and, following the passage of the National Minimum Drinking Age Act of 1984, all 50 states adopted a minimum drinking age of 21 in order to ensure a continued flow of federal transportation dollars. On the state level, after prohibition, most states created either state agencies to issue licenses for retail liquor

# MARYLAND FACULTY USE LAW TO REDUCE ADDICTION AND IMPROVE TREATMENT

Many scholars and advocacy organizations argue that the greatest failure of current drug policy has been the emphasis that it places on investigation, prosecution and incarceration of drug possession offenders, rather than funding, and improving access to, drug screening and treatment. This is also true in the area of alcohol abuse—with more resources going toward punishment of drunk drivers and perpetrators of domestic violence than toward screening and treatment. Inadequate screening for addiction and limited access to quality treatment are widely considered the greatest obstacles to addressing the issue of addiction in the United States. In addition to underfunding and limited capacity, other problems inhibit effective treatment including lack of availability of a wide range of effective treatment modalities, lack of insurance coverage for drug and alcohol treatment, and, in the specific case of drug treatment, the NIMBY (Not in My Backyard) problem that can block the opening of treatment facilities in a community. Law & Health Care Program faculty have been working on finding innovative solutions to some of the more intractable problems of ATOD misuse through their scholarship and the law school's Drug Policy and Tobacco Control Clinics. Some of those efforts are described below.

## SCREENING

Experts in the area of addiction are urging health care providers to become involved much earlier to help identify alcohol and drug problems in their patients. Alcohol and other drug testing and screening can be a useful clinical and public health tool when it can help identify people with alcohol or other drug problems not otherwise identified as needing clinical intervention. Currently, most screening takes place on the job, in the schools, and in the criminal justice system, and is used as an instrument of harassment and punishment rather than a diagnostic tool.

One context in which testing is not being sufficiently used is in medical settings, especially in trauma centers and emergency rooms. Studies repeatedly

show that 40-50% of patients who show up in trauma centers were drinking alcohol at the time of their injuries.<sup>1</sup> Most of these patients are chronic heavy drinkers. The evidence also clearly shows that a brief motivational intervention at such a “teachable moment” reduces alcohol consumption and the associated risk of injury. Experts argue that blood alcohol



*Professor Richard Boldt*

testing should be routinely conducted for patients admitted to emergency rooms for traumatic injuries, and that all legal, procedural, and financial barriers to such testing should be removed.

University of Maryland School of Law Professor Richard Boldt has written about emergency room screening. In his most recent article, “Confidentiality of Alcohol and Other Drug Abuse Treatment Information for Hospitalized Trauma Patients,”<sup>2</sup> Boldt discusses the obstacles to integration of alcohol and other drug abuse treatment services into the health care delivery system. He notes that, despite encouraging statistics and broad support among trauma surgeons and other emergency medical personnel, many trauma centers and emergency departments still do not provide systematic screening and intervention services for all patients. He believes that providers’ concerns about federal confidentiality statutes and regulations governing alcohol and other drug abuse treatment information may be inhibiting their willingness to engage in systematic screening, intervention, and referral activities. Boldt suggests that the federal confidentiality law and regulations may not apply to these kinds of screening and

intervention activities and cautions against any change in current law that might result in inappropriate disclosure of this patient information.

Professor Ellen Weber, Director of the Law School’s Drug Policy and Public Health Strategies Clinic, has investigated the screening of pregnant women for drug use in her scholarship and in clinic projects. In her article, “Child Welfare Interventions for Drug-Dependent Pregnant Women: Limitations of a Non-Public Health Approach,”<sup>3</sup> Weber explored the merits of early medical screening of pregnant women for alcohol and drug use rather than punitive interventions that occur at the time of delivery. More recently, Weber has examined the common hospital practice of conducting drug tests of women at delivery without obtaining informed consent. Such testing often targets women who have participated in drug treatment and poor women of color who have not had adequate prenatal care. The failure to obtain informed consent raises concerns, according to Weber, because these drug tests are the basis for child protective services reports in many states, including Maryland, and may result in the removal of the infant from the mother’s custody. Weber is exploring the ethical and legal basis for requiring informed consent in this context.

In her clinic work, Weber and her students have represented the Maryland Women’s Treatment Coalition in its challenge of the Department of Human Resources policy that requires hospitals to report women and infants who have positive drug tests to child protective services. The focus of their challenge is twofold: the agency has not adopted the policy via the regulatory process required under the Maryland Administrative Procedure Act (APA) and the substantive standards are inconsistent with the state’s child abuse and neglect standard. After two years of negotiation with the state agency to correct the policy, the clinic has petitioned the agency to promulgate the regulations and is seeking an Attorney General opinion regarding the need for promulgation of the regulation. The clinic is seeking to halt the implementation of the policy pending compliance with the APA.

## ACCESS TO DRUG TREATMENT

The 2001 National Household Survey on Drug Abuse found that five million people who needed treatment did not get it and treatment professionals estimate that only one in ten people receive the treatment they need.<sup>4</sup> Among the reasons for this failure are inadequate insurance coverage and a lack of sufficient treatment facilities and options.

### Insurance Coverage

Drug treatment—whether paid for by health insurance or provided by a government entity—is underfunded and difficult to access. More than 70% of people who currently use illicit drugs, as well as 75% of individuals who are alcoholics, are employed and most are covered by health insurance.<sup>5</sup> However, an ongoing concern has been the historic failure on the part of health insurance plans to provide the same coverage for drug and alcohol treatment as they do for the treatment of other medical conditions. The first step toward greater insurance coverage of diagnosis and treatment were mental health parity laws that required health insurers to cover mental health conditions to the same extent physical conditions were covered. However, mental health parity laws did not result in coverage of addiction treatment services as hoped despite the fact that studies found that covering such services does not contribute to healthcare cost increases.<sup>6</sup>

In 1994, Maryland and two other states led the charge in this area by enacting comprehensive mental health parity laws for all state residents.<sup>7</sup> The Maryland law requires non-discriminatory coverage for any person with a mental illness, emotional disorder, drug abuse, and alcohol abuse. The law also provides that, if a company with 50 or more employees provides for inpatient coverage for mental health and substance abuse treatment, those conditions must be covered in the same way that physical illnesses are covered. In 2007, Congress finally passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.<sup>8</sup> The Act does not require health insurance plans to cover addiction or mental health, but insurers will now be barred from imposing any caps or limits on behavioral healthcare services that are not applied to other health conditions if such coverage is offered.

For uninsured, drug dependent individuals, drug treatment options are also very limited. Although research demonstrates

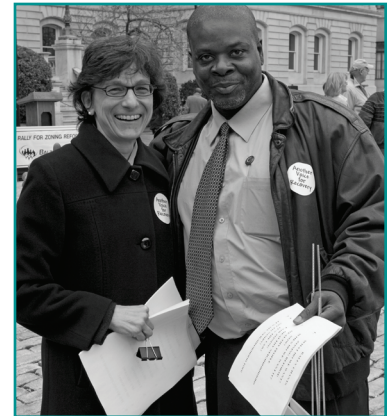
that sound treatment practices and policies save lives, reduce crime, rebuild families and communities, and use public funds wisely, there remains a vast unmet need for treatment. Inadequate funding has led to a longstanding shortage of publicly funded treatment.

Professor Weber and her students in the Drug Policy and Public Health Strategies Clinic have used legal and other advocacy techniques to both force and encourage Baltimore City and the state of Maryland to provide better services. In recent years, Weber has worked with the National Council on Alcoholism and Drug Dependence (NCADD) of Maryland on its Medicaid reform initiative. The Maryland Department of Health and Mental Hygiene (DHMH) was using a comprehensive protocol—the Substance Abuse Improvement Initiative—to ensure easier access to services and more reliable treatment authorization and reimbursement practices but the protocol has been plagued by adherence problems because the standards are not contained in regulations and enforcement has been weak. NCADD, Weber, and clinic students held meetings with providers and DHMH staff to obtain their feedback on the protocol, then developed recommendations for improving the protocol and addressing other issues that have hampered the delivery of services under Medicaid. The clinic also worked with NCADD to spearhead a legislative effort to study Medicaid managed care policies relating to the treatment of addiction. The bill was pulled from consideration by the Maryland General Assembly, but DHMH Secretary John Colmers created a Medicaid Substance Abuse Workgroup to study the issue. The clinic participated in the Workgroup during the summer and fall of 2008 and proposed a number of recommendations to address administrative barriers to accessing addiction treatment services. Among the recommendations that DHMH has agreed to are adoption of the Substance Abuse Improvement Initiative in regulation and improved documentation of denials of care. Clinic students developed the draft regulation and have presented it to DHMH.

### NIMBY Phenomenon

The NIMBY—Not In My Back Yard—phenomenon is another formidable barrier to adequate community-based drug treatment. Many individuals who support drug treatment do so as long as it is not located in their community. Although health and

safety considerations are understandable, they are most often based on misunderstanding and a false sense that drug treatment creates crime and instability in a community. Professor Weber, through the



*Professor Ellen Weber (left)*

Drug Policy Clinic, has been involved in several efforts to oppose NIMBY attitudes and policies. In collaboration with the Citizens Planning and Housing Association (CPHA), Weber and her students participated in drafting a consensus document called “Common Ground—Not Battle Ground: Good Neighbor Principles for Licensed Drug Treatment Providers and the Communities Where They Are Located.” Completed in 2004, this landmark document articulates, perhaps for the first time in the nation, a set of principles that can guide communities and treatment providers to identify treatment opportunities and resources for community residents, and where residents support those in recovery.

Weber and her students also successfully persuaded the Department of Justice to open an investigation of the Drug Policy Clinic’s complaint that Baltimore City’s zoning standards for residential drug treatment discriminate against individuals with histories of drug dependence. Weber and her students filed an extensive Title II (Americans with Disabilities Act) complaint in May 2006 with the Disability Rights Section of DOJ. In May 2007, the Assistant Attorney General for Civil Rights approved the investigation and then determined that the City’s standard violated the ADA. The Mayor of Baltimore introduced legislation to address the problem in December 2007 after months of negotiation between the City, the DOJ, and the Drug Policy Clinic on the appropriate standards. In the past year, the clinic

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has participated in City Council hearings, work sessions and education efforts but has been unable to win passage of the bill by the City Council. In December 2008, the DOJ informed the City that it will file suit if it fails to remedy to problem promptly.

## TREATMENT-RELATED ISSUES

### Drug Courts

In the absence of publicly funded treatment programs, increasingly, people without financial means are only provided with drug treatment through the criminal justice system. After being arrested for drug related crimes, many states, including Maryland, divert offenders into treatment. This often happens through specialized courts commonly referred to as drug courts. Over 2,000 drug courts are currently in place or being planned across the United States. These special dockets are given the responsibility to handle cases involving addicted citizens under the adult, juvenile, family, and tribal justice systems. Adult drug courts started out as diversionary programs dealing with less-serious offenders, typically those charged with simple drug possession or “under the influence” charges. Over time, drug court programs have expanded to probationers, including drug-using offenders charged with non-drug offenses. Typically, only non-violent offenders are eligible for adult drug court.

Although many agree that individuals addicted to drugs should be treated for their illnesses rather than incarcerated as criminals, there is a disagreement over the value of drug courts and other “problem-solving” courts as a way to deal with these individuals.<sup>9</sup> Many experts see them as a cost-effective and humane alternative to incarceration while others worry that drug courts and other diversion programs are available only to a small percentage of eligible and needy individuals, and these models problematically rely heavily on non-therapeutic drug testing and coercion. This debate is thriving among faculty at the Law School.

Professor Brenda Bratton Blom, Director of the Law School’s Clinical Law Program, and her students in the Community Justice Clinic recently drafted an amicus brief in support of the Maryland

Attorney General, appellee in *Brown v. State of Maryland*, which is due to be heard by the Maryland Court of Appeals in its April term. The case, brought by the Office of the Public Defender in Maryland, questions the constitutional and statutory validity of problem-solving dockets in Maryland’s state courts. The amicus brief highlights the constitutional, statutory, and administrative mandates that grant Maryland courts the power to conduct specialized dockets, such as drug and mental health courts. The brief also refutes assertions that these dockets allow



Professor Brenda Bratton Blom

judges to overstep the bounds of their neutral magistracy and enables them to engage in “social engineering” in violation of defendants’ due-process rights.

Professor Richard Boldt has recently written a book chapter entitled, “A Circumspect Look at Problem-Solving Courts,”<sup>10</sup> that questions the “uneasy partnership” of the criminal justice system and drug treatment. In his chapter, and in several other articles he has published on this subject, Boldt explores the disadvantages as well as the advantages of combining therapy with legal coercion in such courts, given the roles assumed by judges, defense lawyers, and other actors in that setting. One of Boldt’s primary concerns is that the therapeutic goals identified by these courts often become debased in practice. This tendency of therapeutic efforts located within the criminal justice system to collapse into more purely punitive responses is especially troubling to Boldt because they often take place in settings where traditional procedural protections are weakened or abandoned. Boldt concludes that it may be appropriate to use problem-solving courts in more limited applications than those currently in practice.

## Treating Addiction with Pharmacotherapies

Historically, drug and alcohol addictions were considered acute disorders best treated through detoxification and other short-term strategies. In recent years, there has been a growing understanding of addiction as a chronic disease that requires long-term relapse prevention therapy. At the same time that our understanding of addiction as a chronic disease has developed, so has the ability to treat patients with pharmacotherapies. While there is a growing body of evidence that the use of pharmacotherapies to treat drug and alcohol addictions is both clinically and cost effective, there are still a number of obstacles that exist to their development and use in the therapeutic setting. In November 2008, the Law & Health Care Program, in collaboration with Physicians and Lawyers for National Drug Policy (PLNDP), held a conference that explored the various impediments that stand in the way of a more robust acceptance of such treatment by regulators, health care providers, patients, and the justice system (See article, p. 9 on conference keynote lecture given by Professor Richard Bonnie).

Panelists at the conference described the obstacles that exist at each stage of drug development and uptake, including obstacles at the pharmaceutical company level; obstacles relating to clinical trials and the FDA approval process; reluctance of patients to use and providers to screen for, and prescribe, medications to treat addiction; and reluctance on the part of insurance companies to adequately reimburse for their use. In addition, because as mentioned above, an important number of individuals receive treatment for their addictions through the criminal justice system, one of the conference panels was devoted to discussion of the reluctance of drug court judges to employ pharmacotherapies. The panel included two drug court judges and a leading sociologist who has studied the use of such treatment in the courts. Another panel took a look at recent efforts to use cutting edge treatments elsewhere in the criminal justice system and in prisons (A video of the conference is available at <http://www.law.umaryland.edu/faculty/conferences/detail.html?conf=71>).

One of the newest medications being used to treat addiction is buprenorphine, a semi-synthetic opiate that can be used

in the management of opioid dependence (that is, dependence on heroin, oxycodone, hydrocodone, morphine, oxycodone and other opioids). The Suboxone and Subutex preparations of buprenorphine were approved for this indication by the FDA in October 2002. The FDA's approval was facilitated by the Drug Addiction Treatment Act of 2000 that, for the first time since 1914, made it legal for doctors to prescribe opioids to manage addiction in an office-based practice. Prior to the passage of the Act, the only medication-based treatment option available to opiate addicts was to obtain methadone treatment at federally-approved outpatient clinics.

The use of medication-assisted treatment in the management of opioid dependence is controversial and highly regulated, owing to the fact that the premise of such treatment is treating an addiction with a medication rather than relying on the abstinence based model that is central to Alcoholics Anonymous and Narcotics Anonymous. A special federal waiver is required to prescribe Subutex and Suboxone for opioid addiction treatment on an outpatient basis. Each approved prescriber is allowed to manage only thirty patients on buprenorphine for opioid addiction as outpatients during his or her first year of treating patients, although Congress has passed a bill relaxing this restriction for group practices.

Buprenorphine has several advantages over methadone treatment. For example, it is generally viewed to have a lower "dependence-liability" than methadone, i.e., withdrawal from buprenorphine is less difficult. Additionally, the opinion of those in the medication-assisted treatment field is generally shifting to longer-term treatment periods (which may last indefinitely) due to the anti-depressant effects Buprenorphine seems to have on some patients, as well as the high relapse potential among those patients discontinuing methadone maintenance therapy. Patients generally prefer buprenorphine over methadone due to the less restrictive outpatient treatment; the less frequent need to go to the clinic for prescriptions; and the reduced "stigma" of going to a doctor's office as compared to making trips to a methadone clinic.

### **Tobacco**

While we often think of drugs and alcohol when we think of addiction, tobacco is another powerful addictive substance. In 1988, Surgeon General C. Everett

Koop in a 618-page report proclaimed that "cigarettes and other forms of tobacco are addicting" and should be treated with the same caution as illegal street narcotics.<sup>11</sup> The report caused doctors, smokers and public health experts and advocates to view tobacco differently—not as a matter of choice, but a matter of addiction.

In the years since, additional research has been done on the addictive properties of tobacco and the resulting difficulty tobacco users face when they try to quit. According to the National Institute on Drug Abuse, of the approximately 70.3 million Americans who use tobacco products annually, nearly 35 million of them want to quit each year but only about six



*Professor Kathleen Dacheille*

percent of people who try to quit are successful for more than a month.<sup>12</sup> Research has shown that nicotine acts on the brain to produce a number of effects, primarily by increasing the level of dopamine in the brain's "reward" circuits. The resulting pleasurable sensations create a physiological demand for additional nicotine that is both physically and psychologically hard to withstand—hence the creation of an addiction. If tobacco users attempt to stop using tobacco, they suffer from nicotine withdrawal—the symptoms of which include irritability, craving, cognitive and attentional deficits, sleep disturbances, and increased appetite. These symptoms often begin within a few hours after the last cigarette, quickly driving people back to tobacco use.

As we reported in our Spring 2007 issue of the newsletter, the law school's Legal Resource Center for Tobacco Regulation, Litigation and Advocacy (the "Center") provides legal resources for community groups, state and local legislatures and agencies, private entities, and lawyers attempting to reduce smoking and its related health impacts in communities and assist

local organizations take a leadership role in developing strategies and advocating for local legislation. In 2005, the Center advocated for insurance coverage of medication for the treatment of tobacco cessation. Although only covering prescription cessation treatment drugs and not over-the-counter drugs like the gum and patch, Maryland Insurance Code section 15-841 now requires that insurers cover tobacco cessation prescription medications if prescription coverage is provided for in the insurance contract. Therefore, since 2005, most insured Marylanders have had access to prescription tobacco cessation medications.<sup>13</sup>

At the current time, Center Director Kathleen Dacheille and her students are working with members of the Maryland General Assembly in support of the following measures:

- **Cigar Packaging Requirement:** a law that would require a minimum pack of four, so that cigars cannot be sold as singles, which are attractive to minors. If enacted, Maryland would be the first state to have such a law.
- **Smoking in Cars with Children:** a law that would prohibit smoking in cars with children eight years of age or younger.
- **Civil Citations for Sales to Minors:** a law that would enhance local governments' power to fine retailers who sell tobacco to minors.

The Center also recently launched a website to assist tenants and landlords dealing with secondhand smoke drift in the multiunit housing setting. The website, [www.mdsmokefreeapartments.org](http://www.mdsmokefreeapartments.org), provides tenants information about their legal rights and how they can be involved to stop the smoke drift problem.

The use of tobacco, and the related addiction and illness that accompany its use, is persistent. Comprehensive and dynamic public health strategies are necessary to prevent initiation and aid in cessation. As rates of tobacco use remain stagnant, this help is essential to the public health community.

<sup>1</sup> Screening, Brief Intervention, Referral, and Treatment of Acute Care Patients for Alcohol Use Disorders, A Position Paper from Physicians and Lawyers for National Drug Policy, available at <http://www>.

# DEAN KAREN ROTHENBERG TO STEP DOWN IN JUNE

Karen Rothenberg announced last spring that she will step down from her position as Dean of the University of Maryland School of Law on June 30, 2009. After a sabbatical, Rothenberg plans to return to the faculty. Rothenberg came to the law school in 1983 and, with Associate Dean Diane Hoffmann who arrived in 1987, created the Law & Health Care Program with Rothenberg serving as its first Director. While she will be greatly missed in her role as Dean, her return to being a full-time member of the Law & Health Care Program faculty will be a boon to the Program's students and the faculty alike.

Although she won't be busy with law school business anymore, Rothenberg shows no sign of slowing down. She will serve as Co-Chair of the World Stem Cell Summit that is taking place in Baltimore this September. The summit will be a gathering of more than 1,500 stem cell



Dean Karen Rothenberg  
Co-Chair of  
2009 World Stem Cell Summit

scientists, physicians, and researchers from the United States and around the world. Sponsored by the Genetics Policy Institute, the 2009 Summit is hosted by the University of Maryland, Johns Hopkins University, Maryland Department of

Business and Economic Development, Maryland Technology Development Corporation, and the Maryland Stem Cell Commission. Rothenberg has served on the Maryland Stem Cell Commission since its inception in 2006 and is currently serving as its Chair.

This summit will be the fifth such summit and promises to be particularly interesting with the recent renewal of federal funding for embryonic stem cell research. The summit will focus on both scientific and non-scientific aspects of stem cell research including progressive research strategies, translational and preclinical findings, cross disciplinary initiatives, drug discovery, funding opportunities (federal, public, and private), commercialization plans, technology transfer platforms, medical tourism challenges, cell banking projects, insurance questions, and international perspectives.

## Addiction and Health Law

Cont. from p. 3

<sup>2</sup> 2007 *Traffic Safety Annual Assessment – Alcohol-Impaired Driving Fatalities*, National Highway Traffic Safety Administration, available at <http://www-nrd.nhtsa.dot.gov/Pubs/811016.PDF>.

<sup>3</sup> U.S. Department of Justice, Bureau of Justice Statistics, *Crime Characteristics*, available at [http://www.ojp.usdoj.gov/bjs/cvict\\_c.htm#publications](http://www.ojp.usdoj.gov/bjs/cvict_c.htm#publications).

<sup>4</sup> CDC, *State Data Highlights*, 2006, available at [http://www.cdc.gov/tobacco/data\\_statistics/state\\_data/data\\_highlights/2006/index.htm](http://www.cdc.gov/tobacco/data_statistics/state_data/data_highlights/2006/index.htm).

<sup>5</sup> *Id.*

<sup>6</sup> Although there is great debate on the subject, several studies have shown that alcohol, tobacco and marijuana can serve as “gateway” drugs that open the door for later use of more serious drugs.

<sup>7</sup> Harrison Narcotic Act, ch. 1, 38 Stat. 785 (1914).

<sup>8</sup> Hoffmann, D., “Treating Pain v. Reducing Drug Diversion and Abuse: Recalibrating the Balance in Our Drug Control Law and Policies,” *St. Louis Journal of Health Law &*

*Policy*, Vol. 1 Issue 2, p. 231.

<sup>9</sup> Hoffmann, *supra* note 8, quoting from Weissman, J., *DRUG ABUSE: THE LAW AND TREATMENT ALTERNATIVES* 117 (1978).

<sup>10</sup> Hoffmann, *supra* note 8, quoting King, R., “The Narcotics Bureau and the Harrison Act: Jailing the Healers and the Sick,” 62 *Yale L.J.* 736, 739 (1953).

<sup>11</sup> See *United States v. Jin Fuey Moy*, 241 U.S. 394 (1916), *Webb v. United States*, 249 U.S. 96 (1919), *United States v. Doremus* 249 U.S. 86 (1919), *United States v. Behrman*, 258 U.S. 280 (1922).

<sup>12</sup> Trebach, A., *LAW AND SOCIETY: THE HEROIN SOLUTION*, New Haven, Conn.: Yale University Press, 1982.

<sup>13</sup> § 1, 21 U.S.C. § 321(g)(1) (1988).

<sup>14</sup> Pub. L. No. 89-74, 79 Stat. 226 (1965).

<sup>15</sup> *The Report of the National Commission on Marihuana and Drug Abuse*, available at <http://www.druglibrary.org/schaffer/Library/studies/nc/nccmenu.htm>.

<sup>16</sup> Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-

513, § 100, 80 Stat. 1236, 1242 (1970).

<sup>17</sup> See, e.g., Galiber, J., “A Symposium on Drug Decriminalization: A Bill to Repeal Criminal Drug Laws: Replacing Prohibition with Regulation,” 18 *Hofstra L. Rev.* 831 (Spring 1998); Mitchell, C., “Deregulating Mandatory Medical Prescription,” 12 *Am. J. L. and Med.* 207 (1986).

<sup>18</sup> Committee on Data and Research for Policy on Illegal Drugs, CF. Manski, et. al., Editors, Committee on Law and Justice and Committee on National Statistics, National Research Council, *Informing America's Policy on Illegal Drugs: What We Don't Know Keeps Hurting Us*, National Academies Press, 2001.

<sup>19</sup> Swift, R., “The Pharmacotherapy of Alcohol Dependence: Clinical and Economic Aspects,” *Pharmacy Practice*, 2001;3 (12):62-66.

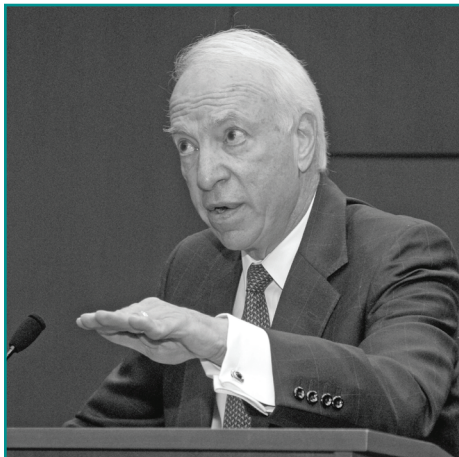
<sup>20</sup> Regier, D.A., et al., “Comorbidity of Mental Disorders with Alcohol and Other Drug Abuse: Epidemiological Catchment Area Study,” *JAMA* 1990 Nov 21;264(19):2511-8.



# STUART ROME LECTURER RICHARD BONNIE SPEAKS AT L&CHP CONFERENCE ON ADDICTION

Professor Richard Bonnie, an expert in the fields of mental health and drug law, was this year's Stuart Rome Lecturer. Bonnie's lecture was the keynote speech at the Law & Health Care Program's November conference "Obstacles to the Development and Use of Pharmacotherapies for Addiction." His talk, "The Virtues of Pragmatism in Drug Policy," will be published in an upcoming issue of the law school's *Journal of Health Care Law & Policy*.

Professor Bonnie, who has been involved in the development of national drug policy for over 30 years, spoke about the need to adopt evidence-based strategies to address drug addiction and move away from the current ideological



*Rome Lecturer Richard Bonnie*

approach that for years has paralyzed the nation's efforts to properly address the problem of addiction. According to Bonnie, in the late 60s and early 70s, policy makers embraced a reformist approach toward addiction that emphasized the need to treat addicts therapeutically rather than criminally. However, exploding drug use in the early 70s alarmed policy makers and led to the initiation of the "War on Drugs" and a zero tolerance approach that rejected reformist views. Bonnie believes that the pendulum is finally swinging away from this approach because it has become increasingly clear that the War on Drugs has caused a great deal of damage at great cost, with little evidence that it has made any impact on drug use or addiction.

Going forward, Bonnie suggests that

drug policy makers adopt three goals—learn how to use the vocabulary of addiction to describe the disease accurately; create incentives and opportunities for addicts to seek treatment voluntarily; and encourage and fund appropriate non-coercive therapeutic treatment of addiction through the criminal justice system. Bonnie argued that experts in the area of addiction need to learn how to speak about addiction in a way that includes the concepts of disease and choice. The current catch phrase of the addiction movement—"addiction is a brain disease"—is accurate but does not capture the volitional components of addiction and relapse. The phrase therefore diminishes a robust understanding and acceptance of the complexity of addiction and how to address it. Bonnie suggests using the concepts of compulsion, predisposition, and an impairment of volition to better explain addiction. He asserts that the concepts of disease and choice can be compatible if explained correctly.

Bonnie's second and third points are related. He believes that, ideally, drug treatment should be widely available to any individual who needs it and that such treatment should be publicly funded for those who cannot afford it otherwise. He argues that incentives—even financial incentives—should be in place to encourage addicts to seek treatment voluntarily. The importance of voluntariness is why he believes that drug treatment through the criminal justice system is so fraught with difficulty—such treatment is essentially forced upon an addict and therefore subject to all the negative consequences of coerced behavior.

In terms of the criminal justice system, Bonnie shared two thoughts with conference attendees. While he strongly supports decriminalization of addiction, he is skeptical of current efforts (through the use of neuroimaging and genetic tests) to use addiction as a defense in the criminal context. He argues that this goes too far in erasing the personal responsibility component of addiction that must be acknowledged. Accepting personal responsibility for behaviors caused by addiction is what addiction therapists teach their clients and

is at the heart of chronic disease management. Bonnie supports the role that the criminal justice system plays in addiction – as a deterrent to criminal behavior associated with addiction and, more importantly, as leverage for therapeutic treatment. He believes that this leverage should be used not to coerce individuals into treatment but to provide them with the choice to begin treatment.

Bonnie is the Harrison Foundation Professor of Medicine and Law, Hunton & Williams Research Professor, and Professor of Psychiatry and Neurobehavioral Sciences at the University of Virginia. He has been Associate Director of the National Commission on Marijuana and Drug Abuse (1971-73); Secretary of the first National Advisory Council on Drug Abuse (1975-80); chair of Virginia's State Human Rights Committee responsible for protecting rights of persons with mental disabilities (1979-85), and chief advisor for the ABA Criminal Justice Mental Health Standards Project (1981-88). He is currently chairing a Commission on Mental Health Law Reform at the request of the Chief Justice of Virginia and participating in the MacArthur Foundation Research Network on Mandated Community Treatment and in a new MacArthur Foundation Initiative on Neuroscience and Law.

## **THE STUART ROME LECTURE**

*The Rome Lecture was established in January 1984 to honor the memory of Stuart Rome, a prominent attorney, community activist, and art patron in the Baltimore area who died in 1983. Past Rome lecturers have included Larry Gostin (Georgetown University), Robert Burt (Yale University), Alta Charo (University of Wisconsin), Nancy-Ann DeParle (former Director of CMS), Paul Steven Miller (University of Washington), William Sage (University of Texas) and Sara Rosenbaum (George Washington University).*

# LAW & HEALTH CARE FACULTY STAFF LEGISLATIVE TASK FORCE ON HEALTH OCCUPATION BOARDS

In Spring 2008, the Maryland Legislature passed HB 811, which created the Task Force on Discipline of Health Care Professionals and Improved Patient Care. The Task Force was created to study and issue recommendations relating to Maryland's 18 health occupations boards. The legislation directed the Task Force to make recommendations regarding board discipline, the organizational structure of the boards and their relationship to the Department of Health and Mental Hygiene (DHMH), and to take measures to enhance fair, consistent and speedy resolution of complaints made against health care providers. Composed of representatives of the health occupation boards, their executive directors, the Office of the Attorney General (OAG), the DHMH, the Office of Administrative Hearings, patient advocacy groups, attorneys who represent licensees before the boards, and consumers of health care services, the Task Force met nine times at the Law School from September 2008 until January 2009 and issued a report with 24 recommendations on January 31st. Law & Health Care Program Director Diane Hoffmann and Managing Director Virginia Rowthorn (along with Carl Ameringer, Professor of Health Policy and Politics at the L. Douglas Wilder School of Government and Public Affairs at Virginia Commonwealth University) were asked to staff the Task Force by Dan O'Brien, Principal Counsel at DHMH.

The origin of the Task Force can be traced to allegations that the Maryland Board of Dental Examiners abused its disciplinary authority by disproportionately disciplining minority dentists. In 2007, Maryland House of Delegates member Shirley Nathan-Pulliam introduced a bill that called for evaluation of, and significant structural changes to the Dental Board. The bill hearing included extensive testimony from licensed dentists who felt that the Board's sanctioning decisions had a differential impact on licensees based on race or ethnicity. The bill was vetoed for technical reasons but in May 2007, the Governor directed the DHMH's Office of the Inspector General (OIG) to audit the

Dental Board with the goal of determining whether the disciplinary operations and sanctioning outcomes of the Board incorporated bias and inequities. The OIG report was somewhat inconclusive because, as it noted, "the Dental Board's data collection system [was] not well suited for analyzing patterns or analyzing consistencies in the handling of complaints." Following completion of the OIG audit,



Maryland Delegate  
Shirley Nathan-Pulliam

numerous other bills were introduced concerning the health occupation boards. In response to all of these bills, the DHMH suggested the creation of the Task Force.

Given the numerous issues which the legislature listed for Task Force study, the Task Force focused its recommendations on four broad areas: fairness (in both process and outcome of board disciplinary actions); timeliness of board action; communication between boards, respondents and complainants, and between boards and the public; and data collection on various aspects of board actions.

Because HB 811 made substantial reference to due process issues, it was one of the most significant issues tackled by the Task Force. For the purpose of discipline, boards work within the framework of administrative law and it was the differences between what due process requires in the administrative law context and what it requires in the judicial context that raised a significant number of concerns for some

Task Force members. In particular, two features of the boards' process raised concerns about conflicts of interest: 1) board members may participate in some cases in both the investigative and adjudicatory phases of a single case; and 2) the OAG provides attorneys to both prosecute board cases and advise boards as board counsel.

As background, in terms of the role of board members, the law in Maryland and most states allows board members to participate in investigating complaints and, later, in the adjudication process. In *Dr. K. v. State Board of Physicians Quality Assurance*,<sup>1</sup> the Maryland Court of Special Appeals approved of this practice noting that "an investigation is not a disciplinary action" that triggers conflict of interest concerns. In terms of the dual role of the OAG, the United States Supreme Court held in *Withrow v. Larkin*<sup>2</sup> that the combination of investigatory, prosecutorial, and adjudicatory functions in an administrative agency is not, in and of itself, a denial of procedural due process rights. Nor does the Administrative Procedure Act prohibit agency personnel engaged in prosecution or investigatory functions from participating in an adjudication to the extent that they are acting as counsel in such a proceeding. The Task Force's recommendations in this area included the requirement that boards have a separate charging committee and guidelines relating to timeliness of charges.

Another significant Task Force recommendation was a requirement that the boards establish sanctioning guidelines. HB 811 required the Task Force to study "[p]otential changes in the disciplinary program of the health occupation boards that will . . . (iii) increase the consistency and fairness of disciplinary outcomes." In order to arrive at more consistent and fair outcomes, the Task Force studied and later recommended the development of sanctioning guidelines. Approximately 20 states have adopted or are considering adopting structured sanctioning systems including Virginia, Ohio, Washington, Florida, Ohio, and Texas.<sup>3</sup>

Sanctioning guidelines provide a framework from which an appropriate

sanction can be reached by a disciplinary board. There are several reasons for adopting sanctioning guidelines: they make sanctioning decisions more predictable; they add an objective element to a process that is inherently subjective; they provide a resource for board members, board staff and attorneys on both sides; they minimize sanctioning inconsistencies; assist board members or staff recall how past cases were decided; and constrain the influence of such undesirable factors as board member identity, overall board makeup, and

relating to the dental board. Given the fact that not all boards know the racial or ethnic background of their licensees, it is difficult to determine whether board disciplinary actions have a differential impact on licensees based on race or ethnicity. Therefore, the Task Force recommended that all boards collect data relating to a licensee's race and ethnicity on licensing applications to provide statistical information that could later be used to verify fairness in licensure and disciplinary processes and to ensure that board member-

tions. In Maryland, several state agencies currently ask applicants for this information as do the majority of the boards.

Hoffmann, accompanied by Rowthorn and Ameringer, testified in Annapolis before the House Health and Governmental Operations Committee regarding the work of the Task Force on February 3. In the weeks following the hearing, bills containing the Task Force recommendations were introduced in both houses of the Maryland General Assembly (H.B. 1275 and S. 956). More information about the Task Force and the final report are available at [http://www.dhmd.state.md.us/reports/pdf/feb09/Other/HB0811\\_TF%20Discipline\\_HC%20Prof.pdf](http://www.dhmd.state.md.us/reports/pdf/feb09/Other/HB0811_TF%20Discipline_HC%20Prof.pdf).

<sup>1</sup> 98 Md. App. 103, 110 (1993).

<sup>2</sup> 421 U.S. 35 at 56 (1975).

<sup>3</sup> Kauder, N. and Carter, E., "An Empirically Based Structured Sanctioning System," *Journal of Medical Licensure and Discipline*, Vol. 90, No. 4 (2004).

<sup>4</sup> A helpful resource in this area was the 2007 survey by the National Health Law Project (NHeLP) which found no prohibition in federal law against collection of racial and ethnic data when used for certain purposes. The NHeLP report is available at [http://www.healthlaw.org/library/item.157293-51State\\_Survey\\_of\\_Assessment\\_of\\_State\\_Laws\\_Regulations\\_and\\_Practices\\_AffectNational\\_Health\\_Law\\_Project](http://www.healthlaw.org/library/item.157293-51State_Survey_of_Assessment_of_State_Laws_Regulations_and_Practices_AffectNational_Health_Law_Project).

*There are several reasons for adopting sanctioning guidelines: they make sanctioning decisions more predictable; they add an objective element to a process that is inherently subjective; they provide a resource for board members, board staff and attorneys on both sides; they minimize sanctioning inconsistencies; assist board members or staff recall how past cases were decided; and constrain the influence of such undesirable factors as board member identity, overall board makeup, and race or ethnic origin on outcomes.*

race or ethnic origin on outcomes.

The legislation creating the Task Force also listed as a topic for study "the extent to which the current disciplinary system has a differential impact on various groups of licensees and potential strategies for minimizing differences while improving the overall quality of health care services." This was in response to prior concerns

ship reflects diversity of licensees.

The Task Force staff researched the legality of collecting such data and determined that there is no federal or state statutory prohibition against collecting this type of information.<sup>4</sup> Further, federal law allows private entities to collect racial and ethnic identity information for certain housing, lending, and banking transac-

## Maryland Law Faculty

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[plndp.org/Resources/SBIRT\\_posit\\_paper.pdf](http://plndp.org/Resources/SBIRT_posit_paper.pdf).

<sup>2</sup> *Health Matrix: Journal of Law-Medicine*, Vol. 20 (forthcoming).

<sup>3</sup> 75 *UMKC L. Rev.* 789 (Spring 2007).

<sup>4</sup> SAMHSA Factsheet: National Household Survey on Drug Abuse, 2001, available at <http://www.whitehousedrugpolicy.gov/drugfact/nhsda01.html>.

<sup>5</sup> Join Together: Ensure Equal Coverage for Treatment, available at <http://www.jointogether.org/keyissues/coverage/equal-treatment-readmore.html>. See also Town M, Naimi TS, Mokdad AH, Brewer RD. "Health care access among U.S. adults who drink alcohol excessively: missed opportunities for prevention." *Prev Chronic Dis* [serial online] April 2006.

<sup>6</sup> In March 2006, the *New England Journal of Medicine* published a study of seven Federal Employee Health Benefits (FEHB) plans from 1999 through 2002.

Study authors found no increase in total costs for FEHB providers when mental health parity was coupled with managed care. Employers, no matter the size, can save at least \$2.15 for every dollar spent implementing alcohol SBIs (screening and brief interventions). Goldman, Howard H., et al., "Behavioral Health Insurance Parity for Federal Employees," *NEJM*, Vol. 354: 1378-1386, No. 13 (March 30, 2006).

<sup>7</sup> In addition, all Federal employees have parity if they are insured through the Federal Employee Health Benefit Plan, which covers 9 million federal employees, their families, and retirees.

<sup>8</sup> Sec. 512 of the Emergency Economic Stabilization Act (H.R. 1424), P.L. 110-343 (2008).

<sup>9</sup> The success of drug courts has spurred the creation of a new generation of so called problem-solving or therapeutic courts, including community courts, men-

tal health courts, domestic violence courts, and others.

<sup>10</sup> The chapter will be included in *PROBLEM-SOLVING COURTS: JUSTICE FOR THE TWENTY-FIRST CENTURY?* (P. Higgins & M. Mackinem eds. 2009) (in press).

<sup>11</sup> *The Health Consequences of Smoking: Nicotine Addiction: Report of the Surgeon General* (1988), Center for Health Promotion and Education, Office on Smoking and Health, Office of the Surgeon General. Davis, R., et al., Editors. Available at <http://profiles.nlm.nih.gov/NN/B/B/Z/D/>.

<sup>12</sup> National Institute on Drug Abuse, Research Report Series, Tobacco Addiction, NIH Publication Number 06-4342. Printed July 1998, Reprinted August 2001, Revised July 2006, available at <http://www.nida.nih.gov/PDF/RRTOBACCO.pdf>.

<sup>13</sup> This provision covers Wellbutrin, Zyban and nasal inhalers.

# FOCUS ON L&HCP STUDENTS

## EXTERNSHIP AT THE CDC *by Rebecca Jesada '10*

After two years of law school and a research assistant position that introduced me to the concept of public health lawyering, I went in search of a summer position that would allow me to work in a setting where public health and the law intersect. I was thrilled when I was accepted as a legal intern at the nation's largest public health agency, the Centers for Disease Control and Prevention (CDC) in their Public Health Law Program (PHLP) in Atlanta.

The mission of PHLP is to improve the health of the public through law. PHLP conducts research on the legal aspects of a wide range of public health issues, from terrorism preparedness and infectious diseases to obesity and lead poisoning. The program produces various forms of training and guidance for state and local health departments and legislators dealing with emerging threats, while working to build partnerships between policy makers, public health practitioners, government officials, and lawyers in an effort to reach creative solutions to public health problems.

As a PHLP intern, the focus of my work was to co-author (in collaboration with a staff attorney) a paper for CDC's National Center for Injury Prevention and Control. The project involved extensive research on state statutes and regulations concerning injury prevention. Our goal was to examine the relationship between states that mandate comprehensive injury prevention programs and those that take more of a piecemeal approach legislatively (i.e.,

enact individual laws with much narrower authority in response to particular community concerns, such as a window guard requirement after a local child is injured).



Rebecca Jesada

Johns Hopkins and Georgetown Universities on a three-part initiative to analyze state tuberculosis (TB) control laws, develop a handbook on TB control laws for an audience of state, local, and tribal public health professionals, and develop a Model Act for states to use in creating or amending their own TB laws. I was fortunate to gain some exposure to the second and third phases of this effort, including editing the handbook and attending the 2008 National Tuberculosis Controllers annual conference, during which a feedback session on the draft Model Act was held with TB controllers from around the country.

Another highlight of the summer was the opportunity to not only attend but participate in the 2008 National Summit on

I also had the opportunity to work on other projects throughout the summer. PHLP is currently collaborating with the Centers for Law and the Public's Health at

Legal Preparedness for Obesity Prevention and Control. The summit was sponsored and hosted by PHLP and CDC's National Center for Chronic Disease Prevention and Health Promotion, along with the Robert Wood Johnson Foundation and the American Society of Law, Medicine, and Ethics. The summit was a remarkable experience, which gave me the opportunity to sit down and share ideas with many of the scholars and authors whose works I have been reading since college.

Reflecting on my summer at CDC, it was truly a unique and valuable experience that exceeded my highest expectations. I got a strong feel for the culture of government work from an attorney's perspective and particularly enjoyed the academic environment, which afforded me significant autonomy in pursuing the injury research. It was inspiring to see what a difference health lawyers can make in the real world, which has fueled my eagerness to continue specializing in health law.

*Becca, who will graduate in 2010 with the Health Law Certificate, is currently a law clerk with the University of Maryland Medical System Office of General Counsel. She has served as a research assistant for Associate Dean Diane Hoffmann and has a professional background in hospital bioterrorism preparedness, including work with Navy hospitals around the world and New York City hospitals. She is also a Notes & Comments Editor of the Journal of Health Care Law and Policy.*

## TOBACCO CLINIC STUDENTS TRAVEL TO SOUTH AFRICA FOR CONFERENCE

As students of the Tobacco Control Clinic, we had the opportunity to travel to Durban, South Africa to participate in Third Annual Conference of the Parties to the World Health Organization's Framework Convention on Tobacco Control with Professor Chris Bostic, a Clinical Instructor in the Tobacco Control Clinic and legal counsel to the Framework Convention Alliance (FCA). The FCA is a non-governmental organization comprised of more than 350 organizations from more than 100 countries working on the development, ratification, and implementation of the international treaty, the Framework Convention on Tobacco Control (FCTC). The FCTC is the world's first global public health treaty, and requires parties to adopt a comprehensive range of measures designed to reduce the devastating health and economic impacts of tobacco.

To kick off the conference, the Minister of Health invited the conference attendees to join her on a health walk through the streets of Durban. Chanting *Vuka, South Africa, Vuka!* (Move, South Africa, Move!), we joined hundreds of people marching together in the streets of Durban holding anti-tobacco signs. Working alongside FCA in Durban to promote the development and implementation of the treaty was professionally gratifying, and an eye-opening experience into the world of public health.

*--Nishamarie Sherry '10 and Jennifer Shahabuddin '09*

# HEALTH LAW STUDENTS WITH ADVANCED HEALTH-RELATED DEGREES

*As the Law & Health Care Program continues to grow in national stature, it is attracting an increasing number of students who arrive at the law school with advanced health-related degrees already under their belts. Our student body now boasts of students with advanced degrees in public health, public policy, medicine, nursing, and social work, among other specialties. Faculty members and students alike deeply value the real world perspective that these students bring to the study of health law. Below, some of these students describe their academic and health care backgrounds.*

## **Caroline Farrell (MPH '07, JD '10)**

I graduated from The George Washington University School of Public Health and Health Services with an MPH with a concentration in health policy in 2007. During my time in the MPH program, I worked as a public policy intern at the National Association of Community Health Centers where I served as an advocate for reauthorization of both the State Children's Health Insurance Program and the Health Centers program. At the School of Law, I am pursuing the health law certificate and have had the opportunity to use my public health training in an externship in the Johns Hopkins Hospital General Counsel's Office, as a health policy fellow at the Health, Labor, Education, and Pension Committee in the United States Senate, and as an intern for the Center for Science in the Public Interest's Litigation Project. I came to University of Maryland Law School to sharpen my advocacy skills. Long term, I hope to contribute to making high quality health care more available, accessible, and affordable for all Americans.

## **Keith Shebairo (MD '01, JD '10)**

I am an adult and child psychiatrist and a 2L day student at the law school. I came to the School of Law because of its highly ranked health law program. Before law school, I earned my MD degree from The George Washington University and completed a residency and fellowship in psychiatry. I am a licensed physician and

board certified in adult psychiatry. Currently, I'm pursuing the health law certificate. Coming back to law school has been an amazing experience for me. Through the health law program, I enrolled this spring semester in the Center for Tobacco Regulation Clinic. Right now I am working on legislation that is being considered by the Maryland General Assembly. In addition, through opportunities at the law school, I interned in the United States Senate Subcommittee on Retirement and Aging this past summer. I have also been active with the law school's national trial team.

## **Lola Burford (MSW '03, JD '10)**

A commitment to social justice requires dedication to advocating on behalf of those who are unable to do so for themselves. I chose to attend the School of Law because of the school's commitment to public interest law, which is aligned with my career interests. I am currently a 2L with a Masters degree in Social Work, from Florida Atlantic University. I have worked in the field of social services for over five years and most recently with the Florida Department of Health's Children's Medical Services in the Pediatric HIV/AIDS division. Completing the Health Law Certificate will enable me to better represent and advocate for vulnerable individuals (children, women, minorities, and the elderly).

## **Jessica Skopac (MA '03, JD/PhD '10)**

I am a 2L day student, pursuing the JD/PhD in Public Policy at University of Maryland Baltimore County. I returned to the law school this semester after a two year leave of absence during which I conducted my dissertation research on health policy in Croatia. Prior to law school, I earned an MA in Bioethics, also from UMBC. From 2000 to 2003 I worked as the legislative liaison for the Maryland Chapter of the Academy of Pediatrics, representing

the group's interests before the Maryland General Assembly. Currently, I'm pursuing the health law certificate and using my bioethics and health policy training in the capacity of research assistant to Dean Karen Rothenberg. After graduation, I hope to find a position as in-house council for a hospital/biotechnology firm/pharmaceutical company or work as a consultant for a think tank.

## **Meg McCoy (MPH '07, JD '09)**

I have always been interested in issues that involve science, health policy, and the law. Before attending Maryland, I worked at the Institute of Medicine on two congressionally-mandated reports about pediatric medical devices and clinical research involving children. In 2007, after my first year in law school, I earned an MPH from the Johns Hopkins University. I was drawn to the School of Law by its health law program's distinguished reputation and proximity to Washington, DC. As part of the Health Law Certificate program, I externed for Stephen Teret at Johns Hopkins' Bloomberg School of Public Health, researching federal preemption of state statutes controlling salt content in food. Last summer, I worked for the Centers for Medicare and Medicaid Services to help finalize federal regulations governing hospital reimbursement.

*Cont. on page 16*



*Advanced Degree Students (from l to r):, Lola Burford, Jessica Skopac, Meg McCoy, and Stephanie Mackowiak. (not pictured, Keith Shebairo and Caroline Farrell)*

# L&HCP FACULTY NOTES

From May 2008 to May 2009

## RICHARD BOLDT

### *Publications*

“Confidentiality of Alcohol and Other Drug Abuse Treatment Information for Emergency Department and Trauma Center Patients,” *Health Matrix: Journal of Law-Medicine*, Vol. 20 (forthcoming).

## KATHLEEN DACHILLE

### *Presentations*

“Youth Access to Tobacco in Cecil County: A Legislative Response,” Cecil County Tobacco Control Task Force, Elkton, Maryland (September 5, 2008).

“Tobacco Legislation in the 2009 Session of the Maryland General Assembly,” Maryland General Assembly of County Health Officers, Annapolis, Maryland (September 18, 2008).

“I’m Just a Bill”: The Maryland Legislative Process and Tobacco Control Legislation in Maryland,” TRASH (Teens Rejecting Abusive Smoking Habits) Annual Conference, Frederick, Maryland (January 11, 2008).

MD QUIT Annual Conference, Baltimore, Maryland: Tobacco and the 2009 Session of the Maryland General Assembly (January 22, 2009).

### *Publications, Writings*

“Amicus Curiae Brief in Support of Respondent in *Altria v. Good*, Supreme Court of the United States, No. 07-562,” filed on behalf of the Center for Tobacco Regulation and the Maryland Consumer Rights Coalition (June 18, 2008).

Law Synopsis: “Pick Your Poison: Responses to the Marketing and Sale of Flavored Tobacco Products,” March 2009 (published by the Tobacco Control Legal Consortium).

### *Media/Interviews*

Quoted in “Ethics Counsel Testimony is Sought in Currie Probe,” *Washington Post*, Page B01, <http://www.washingtonpost.com/wp-dyn/content/story/2008/10/04/ST2008100400071.html> (October 4, 2008).

## MICHAEL GREENBERGER

### *Presentations*

“Germ Warfare, Contagious Disease, and the Constitution,” Speaker, Stanford Constitutional Law Center and the Constitution Project Symposium, Washington, DC (April 11, 2008).

“Public Health and Pandemics,” Presenter, 31st Annual Health Law Professor Conference, Drexel University Earle Mack School of Law, Philadelphia, Pennsylvania (June 7, 2008).

“Emergency Preparedness and the Special Needs Population,” Community Action Partnership 2008 Annual Convention, Chicago, Illinois (August 27, 2008).

### *Media/Interviews*

Panelist, “Naturally Occurring Epidemics and Terrorist Use of Biological Weapons,” C-SPAN (April 11, 2008).

Interview, “Preparation is Key to Avoiding ‘Worst-Case Outcome,’ Chertoff Says,” *The Stanford Report* (April 14, 2008).

## DEBORAH HELLMAN

### *Presentations*

“Doctors, Decision-making and Trust Conflicts,” 31st Annual Health Law Professors Conference, Drexel University College of Law, Philadelphia, Pennsylvania (June 6, 2008).

“Willfully Blind for Good Reason,” University of Toronto Legal Theory Workshop (January 26, 2009).

“Why Put Safety First?” presentation on early phase clinical research at the Association for Practical and Professional Ethics, Cincinnati, Ohio (March 7, 2009).

“Willfully Blind for Good Reason,” University of Southern California Law School, Faculty Workshop (March 13, 2009).

## DIANE HOFFMANN

### *Presentations*

“The Disparity Toward Women in Pain: Social, Cultural and Legal Issues,” First Annual Women in Pain Conference: Gender Matters, City of Hope National Medical Center, Los Angeles, California (May 30, 2008).

“Is Dying a Public Health Issue?” 31st Annual Health Law Professors Conference, Drexel University College of Law, Philadelphia, Pennsylvania (June 6, 2008).

“Health Care Reform at the National Level,” Election 2008: A Forum on Health Care Reform and the Presidential Election, University of Maryland Medical School, Baltimore, Maryland (September 30, 2008).

“Breaking the Law to Treat Patients,” at Richard J. Childress Memorial Conference, Still Crazy After All These Years: Is Regulating Physician Practice an Exercise in Futility?, Saint Louis University School of Law, St Louis, Missouri (October 17, 2008).

Facilitator, “Disparities in Pain Care,” Pain Summit 2008, on Future Directions in Pain Care, Baltimore, Maryland (sponsored by the MD/DC Pain Initiative) (October 24, 2008).

“Are Ethics Committees Doing What We Hoped?” at Health Care Ethics Committees & Maryland Law – Time for a Change? MHECN Conference, Baltimore, Maryland (December 3, 2008).

Berman Lecture, “Case Studies: Genetics in the Courtroom,” The Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland (December 8, 2008).

Greenwall Lecture, “Judging Genes: Implications of the Second Generation of Genetic Tests in the Courtroom,” the Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland (December 8, 2008).

Convener and Moderator: “Comparative Health Law and Policy: What, if Anything, Can We Learn from Other

Countries?" 2009 AALS Annual Meeting, San Diego, California (January 10, 2009).

### **Publications**

"Treating Pain v. Reducing Drug Diversion and Abuse: Recalibrating the Balance in Our Drug Control Laws & Policies," 1 *St. Louis University Journal of Health Care Law and Policy* 231 (2008).

"Achieving Quality and Responding to Consumers—The Medicare Beneficiary Complaint Process: Who Should Respond?" (with Virginia Rowthorn), 5 *Indiana Health Law Review*, 9-51 (2008).

"Are Health Care Conflicts all that Different? A Contrarian View", 29 *Hamline Journal of Public Law & Policy*, 235-242 (Spring 2008).

"Building Public Health Law Capacity at the Local Level," (with Virginia Rowthorn), 36 (Special Supp.) *J. Law, Medicine & Ethics* 6 (Fall 2008).

Book chapter: (with Anita Tarzian), "The Role and Legal Status of Health Care Ethics Committees in the U.S.," in *LEGAL PERSPECTIVES IN BIOETHICS: ANNALS OF BIOETHICS SERIES*, ed. Sandra Johnson, Pub. Rutledge (2008).

### **Other Activities/Appointments/Awards**

Board of Directors, American Society of Law, Medicine & Ethics, (Jan. 2009–present).

Board of Governors, For Grace (an advocacy organization for women with chronic pain) (Jan. 2009–present).

Chair, AALS Section on Law, Medicine & Health Care (2009).

Award, The Daily Record's 2009 Maryland's Top 100 Women.

## **KAREN ROTHENBERG**

### **Presentations**

"Stem Cell Commissions: Politics, Policies and Prospects," 31st Annual Health Law Professors Conference, Philadelphia, Pennsylvania (June 6, 2008).

"Genetics Research and Its Implications for the Jewish Community," Children's National Medical Center Symposium, Washington, DC (June 11, 2008).

"In the Family" Documentary Premier Panel Discussion, Participant, Silverdocs, AFI/Discovery Channel Docu-

mentary Film Festival, Washington, DC (June 18, 2008).

### **Publications**

Book chapter: "The Scarlet Gene: Behavioral Genetics, Criminal Law, and Racial and Ethnic Stigma," (with Amanda Wang) Ch. 13. in *THE IMPACT OF BEHAVIORAL SCIENCES ON CRIMINAL LAW*, Oxford University Press, (March 9, 2009).

### **Media/Interviews**

Interview, WYPR-FM, "Changing the Way We Look at Stem Cells" (March 9, 2009).

Interview, WBFF-TV, Ch. 45, "U.S. Stem Cell Funds Freed; Md. Debates Its Own" (March 9, 2009).

Interview, *The Daily Record*, "Effect of Obama's Stem Cell Reversal Could Take Years" (March 9, 2009).

Interview, *The Washington Post*, "U.S. Stem Cell Funds Freed; Md. Debates Its Own" (March 10, 2009).

Interview, WBAL-AM, "U.S. Stem Cell Funds Freed; Md. Debates Its Own" (March 11, 2009).

Interview, WYPR-FM, "Stem Cell Order Could Be Boon for Maryland" (March 17, 2009).

Interview, NPR "Morning Edition," "States Rethinking Costly Stem Cell Programs" (March 23, 2009).

### **Other Activities/Appointments/Awards**

Co-Chair, World Stem Cell Summit (2009).

Chair, Maryland Stem Cell Research Commission (July 2008).

## **JACK SCHWARTZ**

### **Presentations**

"Apology for Medical Error," Ethics Grand Rounds, Maryland General Hospital, Baltimore, Maryland (October 30, 2008).

"Legal Framework for Advance Care Planning," Geriatric Imperative Minimizer, University of Maryland Baltimore, (January 7, 2009).

"Making Sense of Living Wills and Advance Directives," Kimmel Comprehensive Cancer Center, Johns Hopkins Hospital, Baltimore, Maryland (March 31, 2009).

"Making Sense of Living Wills and Advance Directives," Southern Maryland Caregivers' Conference, Prince Frederick, Maryland (April 17, 2009).

### **Publications, Writings**

"Harnessing Complex Hospital Care: Hospital Practices Must Match the Moral Ends of Treatment," (with Evan DeRenzo and Steven Selinger), *Science Progress* (published online by Center for American Progress) (January 2009).

"Content of Advance Directives for Individuals with Advanced Dementia," (with Patrick Triplett et al.), 20 *Journal of Aging and Health* 583 (2008).

"Surrogate Decision Making: Reconciling Ethical Theory and Clinical Practice," (with Jeffrey Berger and Evan DeRenzo), 149 *Annals of Internal Medicine* 48 (2008).

## **ELLEN WEBER**

### **Presentations**

"Disability Discrimination and Health Privacy Standards," University of Maryland School of Medicine, Addiction Psychiatry Fellows Forum, Baltimore, Maryland (December 22, 2008).

"Reluctance of and Restrictions on Physician Prescribing," Conference on Obstacles to the Development and Use of Pharmacotherapies for Addiction, University of Maryland School of Law (November 7, 2008).

"Protecting Civil and Health Privacy Rights of Patients: The Americans with Disabilities Act and Confidentiality of Patient Records," Maryland Society of Addiction Medicine, Baltimore, Maryland (March 7, 2009).

### **Media/Interviews**

Quoted: "City government seems addicted to delay," *The Daily Record*, (January 30, 2009).

Quoted: "Rawlings-Blake withdraws support for group home measure: City Council president's decision could trigger federal lawsuit," *The Baltimore Sun* (March 16, 2009).

Interviewed: "Zoning bias: Our view: Court fight over group homes law would delay needed zoning changes; instead, City Council should show leadership,

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### Advanced Related Degrees

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#### **Stephanie Mackowiak (BSN '05, JD '10)**

After receiving my undergraduate degree from the University of Richmond, I attended the University of Maryland School of Nursing and graduated with a BSN in 2005. I then worked as a critical care nurse for the Johns Hopkins Hospital for several years before deciding on a career in law. The School of Law has provided me with the unique opportunity to combine my nursing and legal experiences through the Health Law Certificate program. Since arriving at the law school I have been able to use my nursing background in an externship with the Legal Department of the Johns Hopkins Health System. This summer I will be working with MedStar Health and hope to secure a position in a health law related field in the coming year.

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### L&HCP Faculty Notes

Cont. from p. 15

work toward a compromise," *The Baltimore Sun* (March 18, 2009).

#### ***Other Activities/Appointments/Awards***

2009 Public Citizen Award, National Association of Social Workers—Maryland (March 2009).

#### **DEBORAH WEIMER**

##### ***Presentations***

Panelist, "Medical-Legal Partnerships in the Law School Setting," at 2009 AALS Annual Meeting (January 9, 2009).

Speaker, "Current Issues Facing Women Living with HIV," UMB interdisciplinary conference for law, medicine, social work nursing and pharmacy students (January 11, 2009).