Focus on . . .

Access to Health Care

While the United States is one of the richest countries in the world, many people in our nation lack access to health care. Although the primary obstacle to health care access is lack of health insurance or “underinsurance,” a variety of other obstacles contribute to the problem. These barriers range from limited English proficiency and racial, ethnic and other prejudices that may exist within the health care system, to legal obstacles and the threat of liability that may affect the willingness of physicians to provide care. In this article, we briefly discuss each of these obstacles and the ways in which faculty and students within the Law & Health Care Program are attempting to address them through research and scholarship, appointments to state and national task forces, conferences, and work in various health law clinics and externships.

Access to Health Insurance

The most recently available data from the U.S. Census Bureau indicates that almost 44 million people in the U.S. do not have health insurance. Most of these individuals are from low-income working families whose employers do not provide health insurance coverage and almost two-thirds have incomes below 200% of poverty. The vast majority cannot afford to pay for out-of-pocket medical treatment. The problem of lack of health insurance has devastating economic and productive consequences. In recent Congressional testimony, Diane Rowland, Executive Director of the Henry J. Kaiser Family Foundation, testified before the House Appropriations Committee that the uninsured are more likely to become sick and to have longer illnesses than those who have health insurance.
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Access to Health Care

Vice President of the Kaiser Family Foundation, asserted that “[h]ealth insurance matters for the millions of Americans who lack coverage—it influences when and whether they get necessary medical care, the financial burdens they face in obtaining care, and, ultimately, their health and health outcomes.”1 Experts estimate that 18,000 preventable deaths take place each year because of the lack of available and affordable health insurance.2 While insured persons generally have access to preventive treatments, people without health insurance do not have access to services that will prolong their productive lives.3 Moreover, uninsured persons usually do not seek a doctor’s services until their health situation has reached a crisis point.4

The lack of health insurance also contributes to a lack of productivity and impoverishment. Studies have shown that illness experienced by uninsured individuals contributes to work absences and leads to lost wages. In fact, experts estimate that earnings of those without health insurance are 15-20% less than others in comparable jobs with health insurance, as a result of absenteeism related to illness.5 In addition, uninsured families that pay forordinary or catastrophic care, out-of-pocket, face potential financial ruin. According to a study from Harvard Law School, nearly half of all bankruptcies filed in 1999 followed a serious medical problem.6

Unfortunately, the problem of lack of health insurance is growing not declining, despite increasing national prosperity. Reasons for the worsening problem include an increase in the unemployment rate, a drop in employment based coverage, and an increase in the cost of the coverage that is offered. Some of the increase in health care costs and related insurance premiums has been attributed to the weakening of managed care and return to fee for service payments. This has led us back to escalating health care cost inflation. Premiums in some areas are increasing at rates of 15–20% per year.

Although there is widespread agreement that lack of health insurance has far-reaching human costs and profound economic effects on all sectors of our society, there is disagreement among health policy experts, politicians and health care providers regarding the most viable solution to the problem. A recent IOM report outlined several alternatives that have been proposed at the national level for significantly expanding health insurance coverage. These proposals include: (1) establishing a federally-funded, single-payer system, where all enrollees receive a comprehensive benefit package, plus the ability to purchase supplemental coverage for non-covered services ("single payer system"); (2) continuing to provide favorable tax treatment for employment based insurance, establishing a new tax credit for moderate income individuals who purchase health insurance and making Medicare available at age 55 for those who pay a premium ("major public program expansion and new tax credit"); (3) requiring individuals to secure insurance and allowing them to earn tax credits for such purchase ("individual mandate and tax credit"); and (4) mandating that employers provide coverage to their employees and contribute to the premiums (with some subsidy for employers of low wage workers) and requiring that individuals purchase coverage ("employer and individual mandate").7

While efforts at the national level have not been successful, a number of states have taken or are considering bold steps to expand health insurance coverage. Although Hawaii is the only state that requires that employers provide health insurance benefits to workers who work more than 20 hours...
per week, both Maine and California have recently enacted legislation that encourages employers to provide comprehensive health insurance benefits to their employees. In June 2003, Maine enacted legislation that creates a quasi-state agency that will offer health insurance to uninsured individuals, self-employed individuals, and employers with less than 50 workers. Employers who participate in the plan will be asked to pay up to 60% of their employees’ premiums. Uninsured individuals with income that equals up to 300% of the poverty level will qualify for payment assistance with their portion of the insurance premium.

The California legislation, passed in September, 2003, would require employers with 50 or more employees to purchase health insurance for their employees or pay into a statewide pool that would purchase insurance on their behalf—a "pay or play" approach. Employers with 20 – 49 employees would also be required to participate in the plan if the legislature makes available a tax credit to subsidize the cost of the insurance for this group. Before it is implemented, the California legislation faces a significant hurdle—a statewide referendum in November that could overturn it.

In its recent legislative session, the Maryland General Assembly considered legislation that would have significantly expanded health insurance coverage in the state (see article: Maryland’s Health Care for All Initiative, p. 9).

State initiatives to expand health insurance coverage was also the topic of the most recent issue of the Law School’s Journal of Health Care Law & Policy. The issue includes an article by Diane Rowland as well as articles by health policy experts at Johns Hopkins Bloomberg School of Public Health and Florida State University (see article p. 5).

**Barriers Due to Societal or Health System Biases**

Even if individuals have health insurance or can afford to pay for health care, they may lack access as a result of limited English proficiency or biases based on race, ethnicity or other status. In 2003, the Institute of Medicine published its groundbreaking report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. The 400 page report provides ample evidence that racial and ethnic minorities “tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients’ insurance status and income are controlled.” It also cites to a significant body of literature indicating that as compared to whites, African Americans and, in some cases, Hispanics, are less likely to receive appropriate cardiac medication, coronary artery bypass surgery, or peritoneal dialysis and kidney transplantation. Moreover, these minority groups are more likely than whites to receive lower quality clinical services, such as intensive care. In addition to reviewing the evidence regarding these disparities, the report evaluates their potential sources “including bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health system levels,” and makes recommendations as to how to eliminate them. Among the many recommendations made, the report included efforts to increase the proportion of underrepresented U.S. racial and ethnic minorities among health professionals and supporting the use of interpretation services where community need exists.

Last semester, students in Professor Tom Pérez’s Access to Health Care for Vulnerable Populations Clinic had an opportunity to work on proposals in line with these recommendations (see article, p. 6).

Stigma may also create difficulties in access to health care. Students in Professor Ellen Weber’s Drug Policy clinic, and Professor Deborah Weimer’s Health Care/Child Welfare clinic, learn first hand how individuals who are substance abusers or who have HIV illness or AIDS can be victims of discrimination and bias. Articles on pp. 7 and 8 describe the work that students in these two clinics have done to increase access to health care for these two vulnerable groups.

**Legal Barriers to Health Care Access**

Although most of us view the law as a vehicle that we can use to increase access to health care for those who lack it, in some cases the law can actually be a barrier to obtaining necessary health care. Perhaps the most obvious legal barrier is the threat of malpractice suits and, related to that, the high cost in some areas, and for some specialties, of malpractice insurance. Last year, in states such as West Virginia and New Jersey, doctors went on strike to protest rising malpractice insurance premiums. In other states, physicians in high risk specialties have left practice or dropped services. Although in most areas this has not affected access to health care, in rural areas and locations where there is...
While this issue of our newsletter focuses on current ways in which our faculty and students are working on access to health care issues, L&HCP faculty have a long commitment to work in this area. In 1989, Dean Karen Rothenberg, then Director of the L&HCP, published an article in the Houston Law Review entitled “Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care.” In the article, Rothenberg begins by pointing out that “[t]he refusal to treat those in need of emergency care remains a fact of life in this country,” despite the fact that Congress had recently passed EMTALA. She goes on to chronicle the evolution of the legal duty to provide emergency care ending with the passage of EMTALA and critically analyzes the federal statute highlighting its weaknesses—many of which have been addressed since the article was published.

During the last 15 years, since Rothenberg’s article, L&HCP faculty have continued the legacy of exploring legal and other barriers to accessing health care in such contexts as managed care, pain treatment, women’s health and reproductive services, and end of life care.

L&HCP Has Long History of Work on Access to Health Care

Footnotes:


7 See note 2, at 5-6.

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Access to Health Care

Journal of Health Care Law & Policy Devotes Issue to State Efforts to Expand Access to Health Care

The most recent issue of the School of Law's Journal of Health Care Law & Policy includes a number of articles that examine state efforts to expand access to health care. Several of the articles were based on presentations made at the L&HCP's fall, 2002, conference “State Efforts to Expand Health Care Coverage: Current Realities, Future Possibilities?” The lead article, “Advancing Toward Universal Coverage: Are States Able to Take the Lead?” by doctoral students Lisa Dubay and Christina Moylan, and Dr. Thomas Oliver, at the Johns Hopkins Bloomberg School of Public Health, takes the position that because national initiatives to expand access to health care have been largely unsuccessful, state legislatures may be better positioned to expand health care coverage. Yet, the authors also recognize that such efforts by states will not be successful without significant federal resources.

In her article, “Promise and Perils of State-Based Road to Universal Health Insurance in the U.S.,” Dr. Carol Weissert examines the important role that states have played in the health reform movement insofar as they have been willing to enact innovative means to maximize health care spending. Weissert, like Dubay, Moylan and Oliver, perceives that state initiatives to expand access to health care are more likely to succeed if the federal government provides assistance. Rather than having states take the lead alone, however, she advocates a model where states and the federal government work together or a “cooperative federalism” model where the federal and state governments are partners but where states “are held responsible for implementing policies within . . . federal parameters and goals.”

The Journal issue also includes an article by Diane Rowland, Executive Vice President of the Kaiser Family Foundation. The article, “Medicaid: Issues and Challenges for Health Coverage of the Low-Income Population” points to the fact that in the most recent decades Medicaid has served as the primary insurer for the nation’s most vulnerable populations, including poor children and individuals with mental and chronic illnesses or disabilities. Rowland asserts that though states and the federal government currently face budget shortfalls, Medicaid coverage for its vulnerable beneficiaries must not be reduced or eliminated as without it “millions of America’s poorest and sickest people would be without essential health and long-term care services.”

A fourth article by Robyn Whipple Diaz, an attorney in the health law practice group of Crowell & Moring, in Washington, DC, addresses issues of racial disparity in health care access. In the article, “Unequal Access: The Crisis of Health Care Inequality for Low-Income African-American Residents of the District of Columbia,” Diaz argues that “combined racial and economic segregation in hypersegregated inner city neighborhoods have created a crisis of health care access for poor, African-American residents” of D.C. and sets forth some of the factors that have created a disparity in health care treatment between African-Americans and other District residents. She concludes by suggesting that these disparities in health care access can be redressed by preserving affordable access to hospitals and by creating incentives for primary care physicians to practice in sections of the District in which there are high concentrations of African-American residents.

The issue of the Journal is rounded out by an article by Nancy-Ann DeParle, the former Administrator of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services (CMS)) during the Clinton administration. DeParle’s piece, “Medicare at 40: A Mid-Life Crisis?” provides a comprehensive history of the enactment and development of the Medicare program and discusses means by which Congress can continue to improve the program for the rapidly-growing senior population.

The Journal of Health Care Law & Policy (JHCL&P)

This fall, the JHCL&P begins its eighth year of operation.

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ACCESS TO HEALTH CARE

IN THE HEALTH LAW

CLINIC

Access to Health Care for Vulnerable Populations Clinic

The School of Law offers, as part of its regular curriculum, a nationally ranked clinical law program in which faculty members who are practicing attorneys supervise law students who represent actual clients. For those students with an interest in health law, the clinic represents clients in cases involving, among other things, health care for children, legal issues of the disabled, mental illness, AIDS, and the elderly. Clinics in which health law clients are served include Access to Health Care for Vulnerable Populations, Civil Rights of Persons with Disabilities; Drug Policy and Public Health Strategies; Health Care Delivery and Child Welfare: The Challenge of the AIDS Epidemic; Tobacco Control; and Juvenile Law, Children’s Issues and Legislative Advocacy.

Last fall, Professor Tom Pérez established the “Access to Health Care for Vulnerable Populations” clinic at the Law School. Pérez’ background as Director of the Office of Civil Rights (“OCR”) at the U.S. Department of Health and Human Services and his interest in expanding access to health care in underserved communities led him to create this unique and specialized clinic.

Students in the clinic examine the financial, insurance, racial and ethnic barriers that currently stand in the way of providing health services to all citizens and learn about the variety of tools that an advocate can use to enhance access to health care for vulnerable populations. These tools include litigation, legislative and administrative advocacy, and community organizing. Pérez believes that students in the clinic learn first hand that an effective civil rights advocate in the health care context must have many arrows in his or her quiver.

During the classroom component of the clinic, students have an opportunity to study and reflect upon the broader legal and policy issues surrounding access to health care for vulnerable populations. The clinical component involves partnering with non-profit or other entities whose primary mission is to enhance access to health care for vulnerable populations.

A number of students in the new clinic, for example, spent several hours a week working for the National Health Law Program (“NHeLP”) at the U.S. Department of Health and Human Services and his interest in expanding access to health care in underserved communities led him to create this unique and specialized clinic.

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A number of students in the new clinic, for example, spent several hours a week working for the National Health Law Program (“NHeLP”) and one student worked on health care issues for Senator Ted Kennedy (D-MA). Students Pooja Adhakary, Cate Hodgetts and Randi Isaacs worked at NHeLP under the supervision of Professor Pérez and NHeLP Managing Attorney, Steve Hitov (see article p.12). The period that these students spent at NHeLP just happened to coincide with the comment period for a policy guidance document proposed by the U.S. Department of Health and Human Services, Office for Civil Rights (“OCR”). The guidance document addressed the obligations of health care institutions and other providers that receive federal financial assistance to ensure that persons with limited English proficiency (LEP) can meaningfully access health and human services. The document included recommendations for health and human service providers seeking to design effective systems for communicating with patients or clients with limited English skills.

NHeLP spearheaded a national effort to respond to the guidance. Adhakary and Hodgetts assisted in formulating and gathering evidence to support NHeLP’s comments on the proposals and in drafting some of the comments. Over 60 organizations signed on to the comments that were submitted to OCR.

Student Randi Isaacs collected information to help NHeLP staff draft a survey regarding the efficacy of a proposed “national language line”—a telephone call center that would provide physicians treating LEP patients in remote areas with the opportunity to call an interpreter to translate what the

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Drug Policy Clinic Addresses Barriers to Accessing Health Care for Individuals with Drug Problems

Individuals with alcohol and drug problems face numerous barriers to accessing health care for their drug dependence. Treatment is often not available to meet the demand; services are not structured to meet the needs of specific populations, including women, patients with children, and individuals with other disabilities; and private insurance frequently does not cover alcohol and drug treatment. Low income individuals also experience problems obtaining treatment for the myriad health problems that frequently accompany that condition.

Students in Professor Ellen Weber’s Drug Policy and Public Health Strategies Clinic have begun to document the degree to which individuals who receive drug treatment in publicly funded programs experience problems accessing health care. They have also been working extensively to address one systemic barrier to the expansion of treatment services – discriminatory zoning standards for the establishment of alcohol and drug treatment services.

In the spring of 2003, clinic students conducted a needs assessment of individuals participating in drug treatment programs in Baltimore, Maryland to identify their civil legal needs. Among the seventeen areas in which data was gathered, health care ranked first in identified legal problems. Fifty-six percent (56%) of the 200 study participants identified one or more health care issues that posed a potential legal problem. In the areas related to accessing health services, 40% reported an inability to pay for health services; 38% reported not having health insurance; and 25% reported that a provider refused to accept Medicaid or their health insurance. Weber and her students were also interested in learning whether individuals had been denied health care based on either an active drug problem or a history of alcohol or drug dependence; actions that would arguably violate the Americans With Disabilities Act. They learned that relatively few individuals had experienced a denial of health care on this basis, with 7% reporting being denied health care based on their active drug use and 5% based on a history of alcohol or drug dependence.

A significant number of participants also reported problems in accessing drug treatment services. Over 30% reported problems paying for their treatment; 30% reported problems finding treatment that fit their needs; and 26% reported problems enrolling in treatment. Certainly one of the greatest
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Child Welfare Clinic Students Find Many Holes in the Health Care Safety Net

Students in the Health Care/Child Welfare Clinic, directed by Professor Deborah Weimer, have represented several clients with HIV illness challenging determinations by welfare agents that led to these clients and their children losing their health insurance. Because of burdensome recertification demands and residence and work activity requirements, many children with HIV illness are without medical insurance for weeks or months at a time. Overzealous enforcement of new rules accompanying welfare reform has resulted in many HIV+ parents being turned down for temporary cash assistance and medical assistance without good cause. Temporary cash assistance recipients trying to meet the requirement of engaging in a work activity have been illegally terminated from temporary cash assistance when they are unable, due to illness, to fully engage in the work activity. In addition to losing temporary cash assistance, they lose their medical assistance and so do their children.

In one current case, the client, KR, was turned down for temporary cash assistance and medical assistance for herself and her four children due to an alleged “failure to cooperate” with child support enforcement. Clinic students assisted her with an appeal and temporary cash assistance benefits were awarded retroactively. However, she was hospitalized during the period that temporary cash assistance benefits had been denied and medical assistance has not paid the bill. She is now returning to work, but is worried about this $15,000 bill. In addition, her medical assistance should continue for her the first months in her new job, but it was cut off when her temporary cash assistance ended. Weimer and her students are working with KR on both of these issues.

Unfortunately, this example is typical of what struggling poor families face. This client is working hard to achieve the goals set out by welfare reform, but the system is undermining her at every turn.

Children and adults with HIV illness need consistent health insurance coverage. Periodic interruptions due to bureaucratic requirements and mistakes pose great danger to these families. Even a few days interruption in taking HAART (Highly Active Antiretroviral Therapy for Patients with HIV illness — a daily regimen of three drugs taken two or three times each day) can have devastating consequences for a child or adult with HIV illness. They are likely to develop resistance to the medication and lose a whole class of medication that would otherwise be available to them. If people with HIV do lose their medication options, they are likely to become ill and subject to frequent hospitalizations and the state will pay larger medical bills in the long run.

barriers to accessing treatment in many locations, including Baltimore, is the limited availability of treatment services. The City agency that administers the publicly funded treatment system in Baltimore has estimated that, each day, 60% of the fifty individuals who request treatment are turned away because of a lack of space.

Treatment options are also limited because some communities design their zoning standards to exclude programs that serve individuals with this health problem. While local officials voice support for the expansion of treatment, they frequently respond to community opposition to proposed programs by implementing zoning practices, such as community notification and hearing requirements and distance limitations that are not imposed on other health care services. Courts throughout the country have invalidated such practices under both the Americans With Disabilities Act and the Fair Housing Act, but some local jurisdictions continue to erect such barriers based on deeply held, yet unsubstantiated and stereotypical, concerns about the persons who need drug treatment.

The Drug Policy Clinic has relied on these disability rights statutes to propose far-reaching legislative changes to Baltimore’s discriminatory zoning practices. Professor Weber and her students have also sought to implement statewide zoning standards in Maryland for methadone treatment programs and group recovery homes — two of the most frequently targeted treatment modalities — to ensure that these services are permitted to locate like other medical services. Adoption of these standards would expand access to treatment and would also begin to educate the public that drug treatment is a health care service that should be better integrated into the mainstream health care system and made available to all those who need it.
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Maryland's Health Care For All Initiative

In 1998, the Maryland Citizens’ Health Initiative (MCHI) established the Maryland Health Care for All Coalition, the state’s largest health care consumer coalition. It includes religious, health, community, labor, and business groups from across the state. The group’s mission includes “making sure all Marylanders have access to quality and affordable health care; and developing a feasible, economically sound plan to meet that goal.”

Over the past four years, the organization has held 24 town meetings and received input from thousands of state and local organizations and key stakeholders in the health care system, including physicians, nurses, social workers, hospital administrators, safety net providers, government officials and advocates for the disabled, individuals who suffer from mental health problems, children and the homeless. Input from these sources was used by the Initiative to develop a comprehensive health care plan to cover the more than 650,000 uninsured in the state. The plan includes expanding the Maryland small group plan, requiring Maryland businesses either to provide health insurance to their employees or pay a payroll tax to help provide care for the uninsured, requiring every Maryland resident to purchase health care coverage from their employer or other source including a to-be-established independent, quasi-public, health insurer. Subsidies would be provided to individuals below a certain income level.

In 2000, MCHI President, Vincent DeMarco, asked Professor Diane Hoffmann, Director of the Law & Health Care Program, to participate on a technical advisory group to assist the Initiative in the drafting of the plan. See Law & Health Care Newsletter, Vol. IX, No. 1, Fall 2001, for prior coverage of this topic.

While the Initiative has been influential in some incremental reforms, it has not yet persuaded the Maryland General Assembly to adopt a universal coverage plan. This legislative session Health Care for All supported a bill that would have offered a full benefit package to almost 75,000 uninsured Maryland residents. The plan was to be financed by a controversial 2% tax on HMO premiums. As the session came to a close, the bill died as a result of a 22-24 vote on the Senate floor. Despite the loss, the organization remains committed to continuing its efforts to have the state adopt a plan that would provide universal health insurance coverage for all Marylanders.

The Child Welfare Clinic
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In addition to the problems described above, there remains the reality that an HIV+ adult (not yet diagnosed with AIDS) who does not have children residing with him/her is not entitled to Medical Assistance coverage in Maryland. When a parent of an HIV+ child is not properly medicating his/her child, and the child is found neglected and temporarily removed from the parent’s care until the medication issue can be addressed, the parent is no longer eligible for temporary cash assistance or Medical Assistance and loses her health insurance. At the same time Department of Social Services social workers lecture the parent about the importance of taking care of her health as well as her child’s health!

Though students in the Health Care/Child Welfare clinic are working to address these issues on behalf of individual clients, Professor Weimer argues that a systemic solution is desperately needed. The obvious solution, she asserts, "is a simple recognition that all adults and children need and should have health insurance. The bureaucratic and human costs of the Medical Assistance program as currently administered are unconscionable and not fiscally sound."
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Legal Barriers to Access to Health Care

Are Medical Malpractice Premiums a Problem in Maryland?

Last fall there were signs of looming problems in Maryland’s medical liability insurance market. The Maryland Insurance Administration granted a 28 percent increase in the rates charged by Medical Mutual – the primary physician insurer in the state. The state medical society (“Med Chi”) pointed out that the number of carriers actively writing physician medical liability insurance policies in Maryland had declined from 14 in 1996 to one – Med Mutual. Moreover, the medical society argued that the lack of affordable malpractice insurance in the state was having “other more subtle” impacts on provider practices. Indicators of such impacts included the following:

- not one graduate of the University of Maryland School of Medicine last year chose an obstetrics residency;
- physicians are increasingly referring patients to emergency rooms where patients can receive full workups;
- physicians, particularly those in high-risk specialties, are becoming unwilling to provide emergency department on-call coverage because of malpractice concerns;
- one-third of the respondents to a survey by the Maryland Chapter of the American College of Obstetrics & Gynecology said they would stop delivering babies, if their malpractice insurance costs rose by more than 25 percent.

Providers and insurers attributed the increases in premiums to increasing claim severity over the last half decade. At the same time that there were rumblings of a medical malpractice insurance crisis in the state, Public Citizen, a not-for-profit membership organization in Washington, D.C. representing consumer interests, came out with a report: “The Facts About Medical Malpractice in Maryland,” concluding that lawsuits were not responsible for rising medical malpractice insurance premiums in Maryland. The report alleged that the number of medical malpractice claims filed per physician in Maryland had dropped 17.6 percent since 1996 and that the mean medical malpractice payout in Maryland had dropped 29 percent from 1996 to 2002, after adjusting for medical inflation. The report also countered, in response to claims that the state risks many doctors quitting practice or leaving the state if stricter limits are not placed on malpractice awards, by asserting that rather than an “exodus” there has been a consistent increase in the number of resident doctors in the state over the past seven years. Furthermore, the report stated that Maryland has the fourth highest ratio of doctors-to-population among all 50 states and Washington, D.C.

Med Chi and the state hospital association criticized the Public Citizen report stating that it was based on National Practitioner Data Bank (NPDB) information. They argued that NPDB information is incomplete, capturing only claims regarding individual physicians; cases with multiple defendants, claims against hospitals or other corporate entities, and settlements, are not included.

In order to sort out these various perspectives, last October Professor Diane Hoffmann, Director of the Law & Health Care Program, and Professor Roger Wolf, Director of the Center for Dispute Resolution at the University of Maryland, convened a roundtable workshop. The goal of the workshop was to create a neutral environment in which key stakeholders in the debate would be able to examine the issues and, through a facilitated discussion, examine data and develop ideas that would help guide legislators, attorneys, physicians and malpractice insurance companies to structure solutions to the perceived problem. The conveners invited approximately 50 individuals representing physician groups, insurers, trial attorneys, legislators, judges, academics and consumer groups to participate. At least this many individuals attended and the conveners viewed the event as a successful beginning of a dialogue among the experts and affected groups that led to a narrowing of the issues that deserve further focus and discussion.

In a letter sent to participants after the event, Wolf and Hoffmann summarized some of the highlights as described below:

Much of the day focused on attempting to answer the question: Is there a medical malpractice insurance crisis in Maryland? Presentations by Frank Clemente, an author of the Public Citizen report, and David Murray from Medical Mutual, clearly showed that there are significant differences of opinion as to whether there is such a crisis now in Maryland. The differences in their presentations seemed to boil down to discrepancies between the sources of their data and raised questions about the reliability of the NPDB figures.

Several speakers reminded participants that although much attention has been given to tort reforms and damage caps as the way to deal with this “problem,” there is much in the way of “upstream” interventions that can be undertaken with less controversy and perhaps with more effect than downstream solutions. Randy Bovbjerg, an expert on medical malpractice from the Urban Institute, reiterated the benefits...
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of patient safety programs and the need for systems design within health care institutions to reduce medical error. Although he argued that such system changes can pay off in the long run, he also asserted that at the start these programs need an infusion of resources; they cannot just be implemented through good will and reshuffling of existing resources. They require experts, significant planning and, in some cases, new equipment and technology.

Speakers from the Health Ombuds program at Bethesda Naval Hospital and from Johns Hopkins Health System shared successes they have achieved through the implementation of early intervention and mediation programs. In the case of Bethesda Naval Hospital, Carol Houk and Barbara Moidel reported that their ability to intervene soon after an adverse event has occurred, talk to patients, address their concerns and make necessary changes to avoid future similar errors, had resulted in their heading off what might have been the filing of over 200 malpractice claims. Rick Kidwell, Managing Attorney for Claims and Litigation and Director of Risk Management at Johns Hopkins, shared that over the past few years Hopkins has begun to require patients who have filed a malpractice suit against the hospital to have the claim mediated. They have found mediation to be much more efficient, predictable and flexible than the tort system. In addition to providing patients with compensation, he said, it also allows the institution and the injured patient to discuss other forms of redress including improved patient safety, an apology or systems change.

Lawrence Cluff, Assistant Director of Financial Markets and Community Investment at the U.S. General Accounting Office, spoke about the medical malpractice insurance industry. His bottom line was that the sharp premium increases in the insurance industry are cyclical because of the nature of the business. The long tail on claims (i.e., the length of time that may elapse between an injury, and the filing and settlement of a claim) puts the industry in the position of estimating future liabilities and leads to conservative estimates of needed premium income. This may lead to overpricing, followed by periods of underpricing (as a result of a prior cushion from high premiums, competitive pressures and, in some markets, higher than anticipated returns on investments). During the period of underpricing, insurers hope to increase market share. Often the sudden increases in premiums seen by physicians are a result of the industry needing to play “catch up” to cover deferred costs from a prior time when premiums did not cover payouts. When premiums (and profits) rise, new insurers may enter the market with lower prices creating competitive pressure to reduce premiums again. Thus, the cycle repeats itself.

During a discussion based on the presentations, there continued to be debate on whether there is, in fact, a medical malpractice insurance crisis in Maryland. Participants appeared to agree, however, that there needs to be ongoing dialogue and better information about several issues including the following:

- data on the impact of increased premiums on practice and patient care, in particular in the areas of obstetrics and emergency medicine
- how to encourage institutions to invest in patient safety and physicians to adopt patient safety initiatives
- how to encourage institutions to adopt early intervention programs like the health ombuds program or to mediate malpractice claims
- whether there is a need for tort reforms such as damage caps and whether they are worth the unfairness that may result to individuals who are seriously injured or to individuals such as the elderly who will be limited in the economic damages they can receive
- whether there is a need for a short term fix, such as premium subsidies, for certain specialties.

During the recent Maryland legislative session several bills were introduced aimed at alleviating problems associated with increasing malpractice insurance costs. Governor Robert Ehrlich (R) submitted a bill for consideration that would reduce the existing non-economic damages cap from $650,000 to $500,000. In addition, the governor’s bill would have limited the fees that an attorney for a medical malpractice plaintiff could recover. Delegate Joseph Vallario (D), Chairman of the House Judiciary Committee, introduced a bill that would require mediation in malpractice cases as well as a bill to establish a task force to assess the extent of the “problem” and potential solutions. Professors Wolf and Hoffmann met with legislators about the proposed bills and encouraged legislation that would provide useful data to policy makers about malpractice claims, settlements, and awards and their relationship to malpractice premiums.

Ultimately, the legislature declined to pass any of the proposed bills on this topic. In response to this inaction, a spokesperson for Med Chi commented that “[t]he malpractice insurance problem is going to result in an explosion this summer as doctors face another round of huge price increases.”

The difficulty that the legislators faced with respect to passage of any medical malpractice reform initiative, reflects the complexity of a multi-faceted issue that will continue to gain attention in Maryland and a number of other states across the country. Professors Wolf and Hoffmann plan to continue to work with legislators and the affected parties to develop workable solutions to address the impacts of the increasing rates.
The National Health Law Program

The National Health Law Program (“NHeLP”) is a Los Angeles based health care advocacy organization that has a large office in Washington DC. Steve Hitov has served as the managing attorney of NHeLP’s Washington DC office since 2000. Shortly after Hitov joined the organization, Maryland law students began to work with NHeLP, as part of the L&HCP’s practicum and externship program.

NHeLP advocates generally for improved health care access for underserved and vulnerable citizens but more recently is fighting to preserve benefits currently provided under state Medicaid programs. Many states are now confronting record deficits, and, in order to minimize further deficit spending, a number of them have sought to reduce Medicaid benefits and coverage. Because the viability of state Medicaid programs is threatened on an increasingly frequent basis, one of NHeLP’s most important areas of research is gathering information about proposed changes to state Medicaid coverage. NHeLP staff stress to health policy makers that decreasing Medicaid benefits would adversely impact individual Medicaid beneficiaries and overall public health. NHeLP presents its formidable Medicaid research and information to both state and federal politicians so that legislators will better understand the larger consequences associated with reducing Medicaid benefits for poor people. In addition to NHeLP’s work in the field of Medicaid rights advocacy, the organization also devotes substantial time and resources toward improving health care access for vulnerable populations through the enforcement of the entitlements and rights provided by Title VI, the ADA, and Section 504 of the Rehabilitation Act.

Before joining NHeLP in 2000, Hitov worked in different areas of poverty law for nearly 30 years. In addition to bringing a strong commitment to serving poor and underserved communities, when Hitov joined NHeLP he also brought a desire to enhance the relationships that existed between the organization and area law schools. Hitov is dedicated to providing law students with the opportunity to gain meaningful legal experiences that will better prepare them for practice and exposing students to the rapidly expanding substantive area of health care law and advocacy. While he is currently full time at NHeLP, Hitov has significant teaching experience. For four years in the early 1980’s he was an adjunct professor at Western New England School of Law teaching constitutional litigation and running a welfare rights clinic. In 1990, he supervised the mental health clinic at Harvard Law School and taught a seminar on Massachusetts mental health law for the clinical students, and in 1991 and 1992, he supervised students at the Harvard Homelessness Clinic. His background makes him an ideal supervisor for externship and clinic students.

Juliet Choi, a 2003 Maryland Law graduate, completed her L&HCP practicum with NHeLP. During the period that she worked at NHeLP, Choi assisted Hitov with a lawsuit brought by NHeLP on behalf of 10,500 Nebraska Medicaid beneficiaries. Nebraska changed the income limita-

“Hitov is dedicated to providing law students with the opportunity to gain meaningful legal experiences that will better prepare them for practice and exposing students to the rapidly expanding substantive area of health care law and advocacy.”

The Maryland law students placed with NHeLP during this past semester, through Professor Pérez’ clinic, also had a valuable educational experience. Pooja Adhakary, Cate Hodgetts and Randy Isaacs were exceptionally pleased with the experience they gained at NHeLP. All of the students were impressed by NHeLP’s sincere commitment to expanding health care access for society’s most vulnerable segments and are excited about the opportunities that future clinical and externship students will have with the advocacy organization.
Student Completes Practicum at Bazelon Mental Health Center

by Rachel London

In my last semester of law school, through the L&HCP’s externship and practicum program, I had the opportunity to work at the Bazelon Center for Mental Health Law. In short, this is the experience I had been waiting for...the reason I went to law school in the first place. I became interested in mental health advocacy many years ago. My mother is the Executive Director for the Montgomery County Coalition for the Homeless. Since I was very young, I accompanied my mother on her trips to the homeless shelters and saw firsthand how untreated mental illness destroyed peoples’ lives. I majored in Criminal Justice/Criminology in college and decided to go to law school so that I could work as a legal advocate for persons with mental illness. In law school, I enrolled in all of the mental disability law courses that the School of Law offered and I worked at the Maryland Disability Law Center. Working at the Bazelon Center was the culmination of all that I had prepared for. In addition, it enabled me to fulfill the experiential requirement necessary to obtain the L&HCP certificate.

The Bazelon Center for Mental Health Law is the leading national legal advocate for people with mental disabilities. Founded in 1972 and located in Washington DC, the Bazelon Center works to advance and preserve the rights of people with mental illnesses and developmental disabilities. The Bazelon Center was formed by a group of attorneys dedicated to advancing the interests of people with mental illnesses and, in the 30+ years that it has been in existence, has achieved many significant litigation victories. In particular, the Center has obtained positive litigation outcomes in the following areas: access to mental health services and federal entitlements, due process in civil commitments, decreasing discrimination based on mental disability, access to education and the right to live in the community.

Throughout the semester, I have had the opportunity to work to decrease the criminalization of the mentally ill. In particular, I have spent most of my time working with my supervisor, Tammy Seltzer, in preparation for litigation against a county jail that is allegedly treating inmates with mental illnesses improperly. The jail administrators allegedly denied the provision of psychiatric medication to inmates with mental illnesses improperly. The jail administrators allegedly denied the provision of psychiatric medication to inmates with mental illnesses.

My experience at the Bazelon Center has allowed me to use the legal knowledge and writing skills that I gained during law school in the health law litigation context. In addition, I gained invaluable knowledge about mental health law in the real world. In sum, the experience has provided me with everything I was looking for in an externship. If I could continue to work there, I would take a job in a heartbeat!
J aime Doherty has been an adjunct professor at the School of Law since 1997. He currently teaches “Health Care Law: Regulation of Legal and Financial Relationships” as well as a health law seminar on legal issues in managed care. Professor Doherty is a principal with the Columbia, Maryland firm of Pecore & Doherty, LLC, where he and his partner, Jeffrey Pecore, represent hospitals, health systems, individual and group physician practices and other individuals and entities in the health care field. Doherty has practiced health care law since leaving law school in a variety of settings. “I’ve been fortunate enough to practice in different sized national and local law firms, to represent for-profit and tax-exempt entities, to be in-house at both a world-renowned academic medical center and smaller community hospitals, and to represent a variety of physicians and other health care providers in different specialties,” he reflects. It is this vast wealth of practical experience that has made him a popular faculty member among students hoping to gain understanding about complicated health care regulatory and financing issues.

Doherty received a bachelor of arts degree in 1978 from Concordia College in Moorhead, Minnesota, and went on to obtain a JD from Catholic University in Washington DC, in 1985. While attending law school, Doherty worked in Washington DC as the Communications Director for the American Health Lawyers Association, writing and editing for the Health Law Digest and other AHLA publications. “At that time, there was no such thing as a law school with a specialized program in health law, so working for AHLA, being exposed to its Board of Directors and attorney membership, and working at its excellent educational conferences, was the best possible preparation for someone who wanted to practice in this area,” notes Doherty.

“I try to remind the students here how lucky they are to have the kind of curriculum that Deans Rothenberg and Hoffmann and other faculty members have assembled over the years. I would have given anything to have even half of these course offerings available to me in law school.”

After graduation, Doherty spent four years in the boutique, DC, managed care firm of Michaels & Wishner, PC, representing HMOs, PPOs, health insurers and other managed care entities throughout the country. Having represented the “payor” side of the managed care equation, he then decided to get some experience on the “provider” side, becoming Associate Counsel for National Medical Enterprises (now Tenet Health Care), the second largest proprietary hospital chain in the country. Having represented the “payor” side of the managed care equation, he then decided to get some experience on the “provider” side, becoming Associate Counsel for National Medical Enterprises (now Tenet Health Care), the second largest proprietary hospital chain in the country. In 1993, Doherty was presented with a unique opportunity to combine his experience with health care payors and providers by becoming the Senior Counsel for Integrated Services for Johns Hopkins Health System in Baltimore during Hopkins’ formation of its integrated delivery system (“IDS”). While at JHHS, Doherty assisted with the formation of Johns Hopkins Health Care LLC, a physician hospital organization (“PHO”) and Priority Partners, the Hopkins-affiliated Medicaid Managed Care Organization (“MCO”). “Hopkins was essentially forming a comprehensive multi-jurisdictional provider network and operational managed care infrastructure from scratch at a time when everyone thought that full risk IDS models were the wave of the future.”

Immediately prior to starting his own law firm in 1999, Doherty served as the Vice President and General Counsel of New American Health, LLC, a PHO located in Glen Burnie, Maryland. “New American was part of that wave of risk-bearing PHOs that went insolvent in the late 1990s, but I take great pride in the fact that, unlike many of its competitors, it did not file for bankruptcy and managed to pay or settle all of its claims prior to dissolution. As unfortunate as the turn of events was, it became an essential part of my legal evolution — I found out that there is at least as much to be learned in dismantling a health care enterprise in an orderly fashion as there is in constructing one.” Currently, at Pecore & Doherty, LLC, Doherty and his partner maintain a very active health law practice. "Jeff and I cover a fair amount of ground for a two person
firm – corporate and regulatory health care issues for hospitals and physicians, private insurance and government payors, Medicare and Medicaid, antitrust, contracting and some transactional work. We have the great luxury of being able to offer the clients personalized service while practicing in a relatively informal setting most of the time. It still amazes me that, after all of our experience in this area, we still confront unique or novel legal issues on a very regular basis. One of the things that makes this area of practice so interesting to me personally is that it’s constantly evolving at every level – legal, financial, technological, legislative, operational, political.”

In addition to the courses that he teaches at the School of Law, Doherty is also an Associate Faculty member at the Johns Hopkins Bloomberg School of Public Health in their Health Management Program. In addition to his adjunct teaching, Doherty works to give back to the community in an additional respect. He is currently the President and Chairman of the Board of Trustees of the non-profit Baltimore Medical System, Inc., the largest Section 330 federally qualified community health center in the Mid-Atlantic region, whose mission is to address the needs of the medically underserved in the Greater Baltimore area. “BMS is a truly extraordinary organization that works every day to fill the gaps in the local health care safety net. We provide about 100,000 physician visits to 30,000 low income and disadvantaged residents of Baltimore each year, in addition to community outreach, health promotion and prevention programs, school based health services and a variety of grant-funded services.”

“Teaching at the School of Law is one of my great joys,” says Doherty. “The students are very engaged and focused and come from so many health care and non-health care backgrounds that I feel they teach me at least as much as I teach them. Their energy is infectious and their intellectual curiosity makes the classes very stimulating to me as an instructor. My goals in the classroom are to help the students hone their basic legal skills while providing as much of the big picture in health law as I can in the time allotted. I have been very lucky in the experiences that I’ve had thus far in my career and I want to give some of that back and maybe make the jump into actual health law practice a little more seamless for my students than it was for me. These students will be the legal underpinnings of the health care system of the future and I can’t think of too many things I’d rather do than help prepare them for that incredibly vital role.”

In addition to practicing law, Doherty is a member of a rock band. He recently appeared in the faculty follies singing his inspirational I Just Need More Time Blues capturing the attention of procrastinating students in the audience.

Of note, Doherty is the son of James F. Doherty, Sr., the primary legislative architect of the Federal HMO Act of 1973 and its subsequent amendments, including the Tax Equity and Fiscal Responsibility Act of 1982, allowing managed care organizations to participate in Medicare on a risk basis.

"Teaching at the law school is one of my great joys."
**Biodefense Vaccine Development Conference To Take Place at School of Law**

On June 9, 2004, the School of Law will host a one-day conference on “Eliminating Legal, Regulatory, and Economic Barriers to Biodefense Vaccine Development.” The symposium is being sponsored by the Law & Health Care Program, the University of Maryland Center for Health and Homeland Security, and the Middle Atlantic Regional Center for Excellence for Biodefense and Emerging Infectious Diseases Research (MARCE). MARCE is a consortium of 16 universities, led by the Center for Vaccine Development at the University of Maryland School of Medicine. The consortium was recently awarded a $42 million grant from the National Institute of Allergy and Infectious Diseases to develop new and improved vaccines, diagnostic tools, and treatments to help protect the country from the threat of bioterrorism and naturally occurring infectious diseases.

The conference presenters will examine the legal, regulatory, and economic obstacles to biodefense vaccine development and distribution, including examination of the financial market for vaccines, the role of the U.S. Food and Drug Administration’s regulatory process, intellectual property issues, informed consent, and manufacturer and institutional liability. Dr. Anthony Fauci, Director of the National Institutes of Allergy and Infectious Diseases, will deliver a luncheon address on “The NIH Biodefense Research Agenda.” Other speakers will include industry experts, legal academics and public health officials. The conference will be of particular interest to public health officials, medical researchers, food and drug regulation experts, and intellectual property attorneys. For more information about the conference, go to www.law.umaryland.edu/conferences.asp

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**Barriers to End of Life Care**

**Not in My ER, Not in My Nursing Home**

In December 2003, the Maryland Healthcare Ethics Committee Network (MHECN), an arm of the L&HCP, and Baltimore’s Franklin Square Hospital, hosted a conference entitled “Not in My ER, Not in My Nursing Home: Regulatory and Ethical Insights about Dying in Institutions.” At the conference, presenters and attendees explored some of the legal misperceptions that encourage nursing homes and hospitals to treat dying patients like “hot potatoes,” transferring them back and forth at the end of their lives.

Dr. Linda Defeo, an emergency department physician and a graduate of the School of Law, was the motivating force behind the conference. Last spring, Defeo called Professor Hoffmann, complaining that she was seeing an increasing number of terminally ill nursing home patients coming to the emergency department when, in her opinion, they should have been receiving palliative care at their long term care facility. In response to these concerns, Hoffmann convened a meeting of individuals who might shed some light on this issue including representatives from the state Office of Health Care Quality (which licenses hospitals and nursing homes), a representative of one of the state’s nursing home trade associations, a medical director for one of the state’s largest nursing home chains, a nursing home administrator, a long term care attorney, and members of MHECN’s executive board. After lengthy discussion it was clear that much of the transferring of patients from nursing homes to emergency departments is based on misperceptions about legal scrutiny and sanctions when residents die in nursing homes. As a result, the group recommended that MHECN host a conference to discuss (1) the legal and ethical factors that should be considered before transferring terminally ill nursing home residents to the emergency department when they experience life threatening symptoms, e.g., chest pain, and (2) how nursing homes might improve end of life care for their patients.

Presenters included experts from medicine, law, bioethics and nursing. Professor Hoffmann and colleague, Anita Tarzian, PhD, presented the results of a study they had conducted on obstacles to the use of hospice services by nursing homes. Professor Bob Rubinstein, PhD, from the University of Maryland (UMBC) Department of Sociology & Anthropology, spoke about a long term study that he is conducting on the culture of dying in the nursing home.

Of perhaps most interest to many of the participants was the presentation by Bill Vaughan, Chief Nurse, Office of Health Care Quality (OHCQ), Maryland Department of Health and Mental Hygiene. Vaughan’s presentation: “Setting the Record Straight: What State Regulators Expect to Find Regarding End-of-Life Care for Nursing Home Residents,” included a discussion of a case that led the OHCQ to fine a nursing home for failing to
The Student Health Law Organization (SHLO) has over 75 members and works closely with the nationally ranked Law & Health Care Program to provide them with many opportunities to enhance their knowledge of health law issues and to introduce them to area practitioners.

During the past year, the organization organized its annual “Brown Bag Lunch” speaker series. The series allows students to learn about contemporary health law issues in an informal, small setting. Our first speaker was Roberta Ward, a University of Maryland Law grad who is currently Privacy Officer and Senior Counsel for the California Department of Health Services. She spoke with students about the challenges of HIPAA compliance for government health plans. Other Brown Bag Luncheon speakers included Alan Goldberg, an attorney at Goulston & Storrs and adjunct professor at the School of Law, who spoke generally about the use of technology to assist with health law and about the Privacy and Security Practice Group at his firm, and Professor Tom Pérez who spoke about civil rights and health law.

SHLO’s activities in the Fall of 2003 culminated in its third annual “What is Health Law?” panel. At this event, SHLO invited several health law practitioners to speak to students about the vast field of health law. This year students were able to listen to attorneys describe their experiences in medical malpractice, as in-house counsel to a health care institution, in government agencies, and academia.

During the Spring of 2004, SHLO collaborated with the Career Development Office to assist students interested in health law in the networking process. In February, SHLO hosted a panel featuring Associate Dean Dana Hoffmann, Assistant Dean Dana Morris, and Karon Laacke of Lexis-Nexis, to provide students with information about careers in health law and how to find health law jobs and market themselves to health law employers. In March, SHLO hosted a networking event with health law attorneys and students, where booklets including resumes of students interested in health law jobs were distributed to attendees.

In addition to student-organized events, SHLO has been extremely fortunate to be able to participate in events sponsored by professional organizations. In September, SHLO hosted a meeting of the Maryland State Bar Health Law and Elder Law Sections. At this meeting students were able to network with practicing health law and elder law attorneys. In February, the Law & Health Care Program hosted a meeting of the Nurse Attorneys Association, and opened it to SHLO members. At the meeting, students were able to meet area nurse-attorneys. Finally, as part of SHLO’s ongoing affiliation with the American Health Lawyers Association (AHLA), students were able to volunteer at AHLA’s conferences on fraud and compliance and Medicare and Medicaid. In return for volunteering, students received conference materials and were able to attend conference lectures.

All of SHLO’s programs are intended to educate students about health law, to assist them in finding health law careers after law school, and to facilitate their navigation through Maryland’s extensive array of health related courses and opportunities.

L&HCP Ranked in Top Three in U.S. News & World Report Survey

The Law & Health Care Program ranked third in U.S. News & World Report’s 2003 annual survey of law school specialty programs. Since 1995, the L&HCP has been consistently named among the top five health law programs nationwide.
Professor Richard Boldt
Appointment:

Professor Irving A. Breitowitz
Publications:
“Jewish Law and Organ Donation,” Jewish Action (Fall 2003)

Professor Kathleen Dachille
Presentations:
“Disparate Impact on Minorities of Weak Clean Indoor Air Law,” Poster Session, National Conference on Tobacco or Health, Boston, Massachusetts (December 2003)

Professor Michael Greenberger
Publications:

Professor David Hyman
Publications:

Associate Dean Diane Hoffmann
Publications:

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Professor Michael Greenberger
Publications:

Professor David Hyman
Publications:

Associate Dean Diane Hoffmann
Publications:

Presentations:
“Medical Malpractice: Plenty of Blame to Go Around,” Loyola University Health Law & Policy Colloquium, Chicago, Illinois (Fall 2003)

PROFESSOR DIONNE KOLLER
Publications:
“Physician Liability and Managed Care: A Philosophical Perspective,” 19 Georgia State University Law Review 641 (Spring 2003)

PROFESSOR TOM PÉREZ
Publications:


Presentations:
“Making Sense of the Recent Supreme Court Decisions on Affirmative Action,” National Association of Minority Medical Educators, Kansas City, Kansas (Fall 2003)


“Enhancing Diversity in the Health Professions in the Post Michigan Universe,” National Association of Minority Medical Educators, Kansas City, Missouri (Fall 2003)

DEAN KAREN ROTHENBERG
Presentations:
“Genetics Research and Its Implications for the Jewish Community,” American Society for Bioethics and Humanities Conference, Montreal, Canada (October 2003)

“Genetics Research and Its Implications for the Jewish Community,” Southeastern Association of Law Schools Annual Meeting, Amelia Island, FL (July 2003)


PROFESSOR ELLEN WEBER
Presentations:
“Lost Opportunity: Failure to Provide Medical Care for Alcohol and Drug Dependence at the Baltimore City Detention Center,” Maryland Legislative Black Caucus, Law and Justice Workshop, Annapolis, MD (October 2003)

“Failure of the Maryland Department of Public Safety and Correctional Services to Provide Mandated Treatment Services,” before the Senate Special Committee on Substance Abuse, Annapolis, MD (July 2003)

PROFESSOR DEBORAH WEIMER
Awards:
Received 5-year grant from the U.S. Department of Health and Human Services, Administration of Children, Youth and Families (and an additional grant from the Annie E. Casey Foundation) to expand collaborative/interdisciplinary work with Schools of Social Work and Nursing in Healthy Grandparent Project (2003)

PROFESSOR ROGER WOLF
Presentations:
Convener, Roundtable on Medical Malpractice, organized by C-DRUM and Law & Health Care Program, University of Maryland School of Law (October 2003)
adhere to a patient’s advance directive. The case involved a patient (Jane Doe) who had executed a valid advance directive in 1997, when she was 82 years old and still lived in the community. The advance directive instructed her healthcare providers to withhold administration of artificial nutrition through a feeding tube if she was suffering from an “end-stage condition.” Subsequently, Ms. Doe was diagnosed with dementia and moved to a nursing home.

In April 2001, Ms. Doe’s condition deteriorated and she was hospitalized. Her son insisted that the hospital staff insert a feeding tube and the staff complied with this request. A few days later, when Ms. Doe was transferred back to the nursing home, her treating physician determined that tube feeding would be medically ineffective and the decision was made that, in keeping with Ms. Doe’s advance directive, artificial nutrition should be withheld. However, Ms. Doe’s son threatened to take legal action if the nursing home staff did not provide artificial nutrition to his mother. The nursing home complied with the son’s request and provided Ms. Doe with tube feeding for the next few weeks. Ms. Doe was hospitalized in May and soon thereafter died in the hospital. Because the nursing home failed to heed the clear instructions set forth in Ms. Doe’s advance directive when it tube fed her in April 2001, the OHCQ fined the facility $10,000.

Many symposium attendees and presenters agreed that the information exchanged between health, legal and ethical professionals, provided helpful background information that will likely affect end-of-life practices in long term care facilities.