Austin, Texas – Renaissance Hotel

PROGRAM CHAIRS
Annual Meeting Program Co-Chairs
Alejandro Moreno, MBBS, MPH, JD, FACP, FCLM
Daniel L. Orr II, DDS, PhD, JD, MD, FCLM

Dental Session Chair
Bruce Seidberg, DDS, MScD, JD, FCLM
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule at a Glance</td>
<td>4</td>
</tr>
<tr>
<td>Events / Additional Activities</td>
<td>6</td>
</tr>
<tr>
<td>Hotel Floor Plan</td>
<td>6</td>
</tr>
<tr>
<td>Annual Meeting Needs &amp; Objectives</td>
<td>7</td>
</tr>
<tr>
<td>Meeting Guidelines</td>
<td>7</td>
</tr>
<tr>
<td>Annual Meeting Accreditation Information</td>
<td>8</td>
</tr>
<tr>
<td>2016 Scientific Program Schedule</td>
<td>9</td>
</tr>
<tr>
<td>Poster List</td>
<td>13</td>
</tr>
<tr>
<td>ACLM Board of Governors, 2015-2016</td>
<td>14</td>
</tr>
<tr>
<td>ACLM Committee Listing, 2015-2016</td>
<td>14</td>
</tr>
<tr>
<td>ACLM Past Presidents</td>
<td>16</td>
</tr>
<tr>
<td>Gold Medal Award Recipients</td>
<td>17</td>
</tr>
<tr>
<td>Honorary Fellows</td>
<td>17</td>
</tr>
<tr>
<td>Speaker/Presenter Bios</td>
<td>18</td>
</tr>
<tr>
<td>Program Materials</td>
<td>28</td>
</tr>
</tbody>
</table>
### 2016 ACLM 56th Annual Meeting

#### Schedule-at-a-Glance

**Thursday, February 25**

- **Noon - 6:00pm**
  - Registration Desk - Grand Ballroom Foyer

- **Noon - 5:00pm**
  - ACLM Board of Governors Meeting - Concho

- **7:00 - 10:00pm**
  - Committee Meetings - Concho

**Friday, February 26**

- **6:00am - 5:30pm**
  - Registration Desk - Grand Ballroom Foyer

- **6:45 - 7:45am**
  - Past Presidents Breakfast - Guadalupe

- **7:00 - 8:00am**
  - Continental Breakfast - Grand Ballroom Foyer

- **7:45 - 8:00am**
  - Welcome/Announcements - Grand Ballroom A
  - ACLM Annual Meeting & Dental Chairs:
    - Alejandro Moreno, MBBS, MPH, JD, FACP, FCLM
    - Daniel L. Orr II, DDS, PhD, JD, MD, FCLM
    - Bruce Seidberg, DDS, MScD, JD, FCLM

- **8:00 - 9:50am**
  - Joint General Session I - Grand Ballroom A
  - RECENT DEVELOPMENTS IN LEGAL MEDICINE

- **9:50 - 10:00am**
  - Networking Break - Glass Oaks Ballroom

- **10:00 - 11:00am**
  - General Session II - Grand Ballroom A
  - DISCIPLINARY ISSUES OF HEALTH PROFESSIONALS

- **11:00am - Noon**
  - Stewart Reuter Lecture (Ethics) - Grand Ballroom A
  - VOICES FROM THE STORM: HURRICANE KATRINA FROM INSIDE CHARITY HOSPITAL
  - This lecture made possible through a grant from the ACLM Foundation
  - Ruth Berggren, MD, FACP, Director, Center for Medical Humanities and Ethics, University of Texas Health Science Center San Antonio

**Saturday, February 27**

- **6:00am - 5:30pm**
  - Registration Desk - Grand Ballroom A

- **6:45 - 7:45am**
  - Dr. Dorothy Rasinski-Gregory Women’s Leadership Breakfast - Wedgewood Ballroom

- **7:00 - 8:00am**
  - Continental Breakfast - Glass Oaks Ballroom

- **8:00 - 9:45am**
  - Joint General Session III - Grand Ballroom A
  - INNOVATIVE SOLUTIONS TO HEALTH POLICY PROBLEMS

---

All General and Breakout Sessions include a Q&A.

Joint General Sessions include both Scientific and Dental Programs.

Schedule subject to change.
9:45 - 10:00am Networking Break - Glass Oaks Ballroom

10:00 - 11:50am Breakout Session III (Ethics) - Grand Ballroom A
PHYSICIANS, DENTISTS, AND LAWYERS AS DEFENDANTS

10:00 - 11:50am DENTAL SESSION V - Brazos

11:50 - Noon Networking Break - Glass Oaks Ballroom

Noon - 1:15pm Cyril Wecht Luncheon - Wedgwood Ballroom
This lecture made possible through a grant from the ACLM Foundation
Richard Adler, MD, Forensic & Clinical Psychiatry
(All attendees are invited with additional registration cost; this meal is not included in your registration fee.)

1:30 - 3:15pm Breakout Session IV - Grand Ballroom A
TERMINALLY ILL PATIENTS AND IMMIGRANTS

1:15 - 3:00pm DENTAL SESSION VI - Brazos

3:15 - 3:30pm Networking Break - Glass Oaks Ballroom

3:30 - 4:45pm Sandy Sanbar Joint Lecture (Ethics) - Grand Ballroom A
CONFRONTING TRAUMATIC BRAIN INJURY: DEVASTATION, HOPE, AND HEALING
William J. Winslade, PhD, JD, James Wade Rockwell Professor of Philosophy in Medicine, Institute for the Medical Humanities, University of Texas Medical Branch Galveston and Distinguished Visiting Professor of Law and Associate Director for Graduate Programs, University of Houston School of Law

4:45 - 6:30pm Annual Meeting of the Fellows - Grand Ballroom A

6:30 - 7:00pm Networking Reception - Glass Oaks Ballroom

7:00 - 9:00pm Annual Awards and Networking Banquet - Glass Oaks Ballroom
PATIENTS, OUR MOST VULNERABLE POPULATION: WHERE ARE WE 15 YEARS AFTER THE INSTITUTE OF MEDICINE REPORTS ON SAFETY AND QUALITY IMPROVEMENT?
Kenneth I. Shine, MD, MACP, Special Advisor to the Chancellor, University of Texas System
(All attendees are invited with additional registration cost; this meal is not included in your registration fee.)

Sunday, March 28

7:00am - 1:00pm Registration Desk - Grand Ballroom Foyer

7:00am - 1:00pm POSTER SESSIONS - Glass Oaks Ballroom

7:00 - 8:00am Continental Breakfast - Glass Oaks Ballroom

8:00 - 9:15am General Session IV - Grand Ballroom A
ELDERS AND THE UNINSURED

9:15 - 9:30am Networking Break - Glass Oaks Ballroom

9:30 - 10:35am General Session V - Grand Ballroom A
STUDENT WRITING AWARDS

10:35 - 10:45am Networking Break - Glass Oaks Ballroom

10:45 - 12:15pm General Session VI (Ethics) - Grand Ballroom A
ETHICAL DILEMMAS WITH VULNERABLE AND SPECIAL POPULATIONS

12:15 - 12:30pm Closing Remarks - Grand Ballroom A

All General and Breakout Sessions include a Q&A.
Joint General Sessions include both Scientific and Dental Programs.
Schedule subject to change.
EVENTS / ADDITIONAL FUNCTIONS

EVENING FUNCTIONS

As a benefit of membership, a ticket to the President’s Welcome Reception is included with your full conference registration. Additional tickets may be purchased for guests and single day registrants.

**President’s Welcome Reception**

- **Date:** Friday, February 26, 2016
- **Time:** 6:30 pm – 8:30 pm
- **Location:** Arbor
- **Attire:** Business Casual
- **Cost:** One ticket is included in your full conference registration fee. Additional tickets are $25.00 each

Take some time to catch up with colleagues and meet new friends in the medical-legal community over cocktails and light hors d’oeuvres at the annual ACLM President’s Welcome Reception.

**Annual Awards and Networking Banquet**

- **Date:** Saturday, February 27, 2016
- **Time:** 7:00 pm – 9:00 pm
- **Location:** Glass Oaks Ballroom
- **Attire:** Business
- **Cost:** $100 - ticket price purchased at conference. Tickets are not included in the registration fee.

ADDITIONAL FUNCTIONS

**Dr. Dorothy Rasinski-Gregory Women’s Leadership Breakfast**

- **Date:** Saturday, February 27, 2016
- **Time:** 6:45 am – 7:45 am
- **Location:** Wedgwood Ballroom
- **Attire:** Business Casual
- **Cost:** Included in registration fee

Join us for the 10th Annual Dr. Rasinski-Gregory Women’s Leadership Breakfast. Share your career transition experiences and become more involved in the ACLM committees and educational programs.

**Cyril Wecht Luncheon**

- **Date:** Saturday, February 27, 2016
- **Time:** 12:00 pm – 1:15 pm
- **Location:** Wedgwood Ballroom
- **Attire:** Business Casual
- **Cost:** $75 - ticket price purchased at conference. Tickets are not included in the registration fee.

HOTEL FLOOR PLAN
Educational Needs

Physicians, dentists, attorneys and educators who practice in the healthcare industry and its related fields recognize that the practice of medicine is complicated by abundant legislative requirements, administrative rules and regulations and Federal/State court decisions interpreting those laws. It is difficult to maintain a working knowledge of these developments. This meeting will provide details of new legislation, rules and court decisions, societal changes and shifts in the market place that will impact the practice of medicine, special and vulnerable populations in particular. Key changes impacting the practice of medicine and law during the past one to two years include: fraud investigations against health professionals, the ethical and legal issues of individuals with traumatic brain injury, the push delivery of care models that emphasize quality and safety within multidisciplinary teams, challenges to the Affordable Care Act, issues with vaccinations and personal exemptions, and individuals with mental health problems in front of civil and criminal courts.

Objectives

The 56th Annual Conference of the American College of Legal Medicine will focus on topics related to the intersection of health law and vulnerable/special populations. By the conclusion of this meeting, participants should be able to:

1. Describe recent legislative and court opinions affecting medical and dental practice.
2. Integrate medical and legal ethics into their daily practice.
3. Identify techniques for overcoming personal impediments to a fulfilling professional practice.
4. Explain legal and ethical challenges of dealing with vulnerable and special populations.
5. Translate the impact of globalization on public health, epidemics and the use of police power to enforce quarantines and mandate vaccinations.
6. Integrate new regulatory changes into current practice.
7. Identify the advantages and disadvantages of Medicare/Medicaid fraud enforcement.
8. Explain the legal issues affecting adolescents refusing medical care or accessing certain medical services on their own.
9. Describe dental and legal issues involved in today’s healthcare.

COPYRIGHT NOTICE

Individuals may print out single copies of abstracts or slides contained in this publication for personal, noncommercial use without obtaining permission from the author or the ACLM. Permission from both the ACLM and the author must be obtained when making multiple copies for personal or educational use, for reproduction for advertising or promotional purposes, for creating new collective works, for resale or for all other uses.

FILMING/PHOTOGRAPHY STATEMENT

No attendee/visitor at the ACLM 56th Annual Meeting may record, film, tape, photograph, interview, or use any other such media during any presentation, display, or exhibit without the express, advance approval of the ACLM Executive Director. This policy applies to all ACLM members, non-members, guests, and exhibitors, as well as members of the print, online, or broadcast media.
CME Accreditation Statement
The American College of Legal Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medicine education for physicians.

The American College of Legal Medicine designates this live activity for a maximum of 19.25 AMA PRA Category I Credits™, which includes a maximum of 4.25 of Medical Ethics hours credits. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Conflict Resolution Statement
The American College of Legal Medicine has reviewed this activity’s speaker and planner disclosures and resolved all identified conflicts of interest applicable.

CLE Accreditation Statement
The American College of Legal Medicine designates this program for up to 19.25 hours of Continuing Legal Education (CLE) credit, which includes a maximum of 4.25 Legal Ethics credits. The precise amount of the CLE will vary by state.

Dental Credits
The American College of Legal Medicine is designated as an Approved PACE Program Provider by the Academy of General Dentistry. The formal continuing education programs of this program provider are accepted by the AGD for Fellowship/Mastership and membership maintenance credit. Approval does not imply acceptance by a state or provincial board of dentistry or AGD endorsement. The current term of approval extends from 12/18/2015 to 12/17/2016. Provider #211173.

General Disclaimer
The statements and opinions contained in this program are solely those of the individual authors and contributors and not of the ACLM. The appearance of advertisements is not a warranty, endorsement or approval of the products or services advertised or of their effectiveness, quality or safety. The content of this publication may contain discussion of off-label uses of some of the agents mentioned. Please consult the prescribing information for full disclosure of approved uses. The ACLM disclaims responsibility for any injury to persons or property resulting from any ideas or products referred to in the abstracts or advertisements.

Special Assistance/Accommodation Statement
We encourage participation by all individuals. If you have a disability, advance notification of any special needs will help us better serve you. Call (847) 447-1713 or email kellyf@ewald.com if you require special assistance to fully participate in the meeting.

Policy on Faculty and Sponsor Disclosure
It is the policy of the American College of Legal Medicine that the faculty and sponsors disclose real or apparent conflicts of interest relating to the topics of this educational activity, and also disclose discussions of unlabeled/unapproved uses of drugs or devices during their presentation(s). Detailed disclosures will be made in the course handout materials.

DISCLAIMER STATEMENT
Statements, opinions and results of studies contained in the program and abstracts are those of the presenters/authors and do not reflect the policy or position of the ACLM, nor does the ACLM provide any warranty as to their accuracy or reliability.

Every effort has been made to faithfully reproduce the abstracts as submitted. However, no responsibility is assumed by the ACLM for any injury and/or damage to persons or property from any cause, including negligence or otherwise, or from any use or operation of any methods, products, instruments or ideas contained in the material herein.
Thursday, February 25

Noon - 6:00pm  Registration Desk - Grand Ballroom Foyer

Noon - 5:00pm  ACLM Board of Governors Meeting - Concho

7:00 - 10:00pm  Committee Meetings - Concho

Friday, February 26

6:00am - 5:30pm  Registration Desk - Grand Ballroom Foyer

6:45 - 7:45am  Past Presidents Breakfast - Guadalupe

7:00 - 8:00am  Continental Breakfast - Grand Ballroom Foyer

7:45 - 8:00am  Welcome/Announcements - Grand Ballroom A

ACLM Annual Meeting & Dental Chairs:
Alejandro Moreno, MBBS, MPH, JD, FACP, FCLM
Daniel L. Orr II, DDS, PhD, JD, MD, ACLM, FCLM
Bruce Seidberg, DDS, MScD, JD, FCLM

8:00 - 9:50am  Joint General Session I: RECENT DEVELOPMENTS IN LEGAL MEDICINE - Grand Ballroom A

» Federal and State Legislative Updates (30)
» Federal and State Court Updates (37)
» Regulatory Agency Updates
» Q & A
Moderator: Theodore R. LeBlang, JD, FCLM
Panelists: Veling W. Tsai, MD, JD, FCLM,
Caring ENT; Gretchen E. Leach, JD;
Hilary H. Young, JD

9:50 - 10:00am  Networking Break - Grand Ballroom Foyer

10:00 - 11:00am  General Session II: DISCIPLINARY ISSUES OF HEALTH PROFESSIONALS - Grand Ballroom A

» Disciplinary Issues Before a Licensing Agency of Physicians with Behavioral and Mental Health Problems (41)
» Practical Risk Management for Physicians: Avoiding Unwanted Attention from Licensing Boards (44)
» Q & A
Moderator: David Donnersberger, MD, JD, FCLM
Panelists: Katherine A. Hawkins, MD, JD, FCLM;
Tim Weitz, JD, CAE

10:00 am - Noon  DENTAL SESSION II - Brazos
Moderator: Joseph P. Graskemper, DDS, JD, FCLM, DABMM

10:00 - 10:25am  Title IX Issues in Dental Education (Sexual Harassment or Assault) (180)
Margaret Hill, DMD

10:25 - 10:50am  Title 21 United States Code (USC) of Controlled Substances Act
Richard Harold, DMD, JD, FCLM

10:50 - 11:15am  Legal Issues in Dental Public Health
Katherine Weno, DDS, JD

11:15 am - Noon  Social Media and the Private Practitioner (184)
Karin Zaner, JD

11:00am - Noon  Stewart Reuter Lecture (Ethics): VOICES FROM THE STORM: HURRICANE KATRINA FROM INSIDE CHARITY HOSPITAL - Grand Ballroom A
This lecture made possible through a grant from the ACLM Foundation
Moderator: Robert W. Buckman, PhD, FCLM, President ACLM Foundation
Presenter: Ruth Berggren, MD, FACP, Director, Center for Medical Humanities and Ethics, University of Texas Health Science Center San Antonio

Noon - 1:00pm  Lunch on Your Own
**Friday, February 26** (continued)

1:00 - 2:45pm  
**Breakout Session I: HEALTH LAW AT THE CROSSROADS OF EPIDEMICS AND CATASTROPHES - Grand Ballroom A**  
» State Preparedness: Legal and Logistical Challenges  
» Vaccination and Quarantine: Revisiting Police Power in the 21st Century  
» Emergency Room Preparedness (58)  
» Q & A  
**Moderator:** Victoria Green, MD, MHSA, JD, MBA, Past-President ACLM  
**Panelists:** Monique Anawis, MD, JD, FCLM; Eli N. Avila, MD, JD, MPH, FCLM; Darren P. Mareiniss, MD, JD, MBE

1:00 - 2:45pm  
**DENTAL SESSION III - Brazos**  
**Moderator:** Bruce Seidberg, DDS, MScD, JD, FCLM

1:00 - 1:30pm  
**Fraud Allegations Against Health Provider: A Personal Experience** (192)  
Leonard Morse, DDS

1:30 - 2:00pm  
**ICD-10 vs CDT 2015-2016** (202)  
Daniel L. Orr II, DDS, PhD, JD, MD

2:00 - 2:30pm  
**The Ethical Mindset: Nature or Nurture?**  
Leeann Podruch, DDS, JD

2:45 - 3:00pm  
**Networking Break - Glass Oaks Ballroom**

3:00 - 5:00pm  
**Breakout Session II: CURRENT CONTROVERSIES IN PEDIATRICS - Grand Ballroom A**  
» Health Law at the Crossroads (70)  
» Access to Contraceptives and Other Family Planning Methods by Adolescents (71)  
» Forced Medical Treatment of Adolescents  
» Q & A  
**Moderator:** Martin J. Stillman, MD, JD, FCLM  
**Panelists:** Dan W. Bolton, III, DC, DO, JD, LLM, FCLM; John Goldenring, MD, MPH, JD, FCLM; Mary Lou Gaeta, MD, JD, FCLM

3:00 - 5:00pm  
**DENTAL SESSION IV - Brazos**  
**Moderator:** Frank Riccio, DDS, JD, FCLM

3:00 - 3:35pm  
**On Your Radar Screen: Rules, Regulations and Requirements**  
Dean Mert Aksu, DDS, JD, FCLM

3:35 - 4:10pm  
**Rules Impacting the Practice of Dentistry Continued**  
Pamela Zarkowski, JD, FCLM

4:10 - 4:45pm  
**Ethics in the Operatory**  
Chester Gary, DDS, JD, FCLM

6:30 - 8:30pm  
**President’s Welcome Reception - Arbor** (One ticket is included in your registration fee.)

**Saturday, February 27**

6:00am - 5:30pm  
**Registration Desk - Grand Ballroom Foyer**

6:45 - 7:45am  
**Dr. Dorothy Rasinski-Gregory Women’s Leadership Breakfast - Wedgwood Ballroom**

7:00 - 8:00am  
**Continental Breakfast - Glass Oaks Ballroom**

---

*Numbers in parenthesis reference page numbers for available session handouts. All General and Breakout Sessions include a Q&A. Joint General Sessions include both Scientific and Dental Programs. Schedule subject to change.*
Saturday, February 27 (continued)

8:00 - 9:45am

**Joint General Session III:** **INNOVATIVE SOLUTIONS TO HEALTH POLICY PROBLEMS** - Grand Ballroom A
- Defendants with Mental Health Issues and the Criminal Justice System: How Do We Stop the Revolving Door?
- Is it Time for Revolution in Health Innovation? (74)
- Q & A

**Moderator:** Richard S. Wilbur, MD, JD, FCLM  
**Panelists:** The Honorable Karen Sage, 299th Texas District Court; S. Claiborne Johnston, MD, PhD, Dean, University of Texas at Austin Dell Medical School

9:45 - 10:00am  
**Networking Break** - Glass Oaks Ballroom

10:00 - 11:50am

**Breakout Session III (Ethics):** **PHYSICIANS, DENTISTS, AND LAWYERS AS DEFENDANTS** - Grand Ballroom A
- Participation of Physicians and Lawyers in Racial Hygiene During the Third Reich (92)
- What Are the Medical-Legal Aspects of Being a Ship Doctor? (97)
- Fraud Allegations Against the Health Provider: A Personal Experience: What if You Find Yourself on the Receiving End of Prosecutorial Misconduct? (98)
- Policy Limits, Payouts, and Blood Money: Medical Malpractice Settlements in the Shadow of Insurance (108)
- Q & A

**Moderator:** Dale H. Cowan, MD, JD, FCLM  
**Panelists:** Karin W. Zucker, MA, JD, LLM, MFS, FCLM; Paul Blaylock, MD, JD, FCLM; Leonard Morse, DDS; Charles Silver, JD, MA

10:00-11:50am

**DENTAL SESSION V** - Brazos
**Moderator:** Kalu Ogbureke, DDS, JD, FCLM

10:00-10:25am  
**Criminal Liability of Healthcare Practitioners**  
**Frank Riccio,** DDS, JD, FCLM

10:25-10:50am  
**“Does Your Board of Doctors Need a Doctor?” Healthy Corporate Governance**  
**Douglas Wolff,** DDS, JD, FCLM

10:50-11:15am  
**Sleep Apnea in Dentistry**  
**William G. Leffler,** DDS, JD, FCLM

11:15-11:50am  
**Hired? Now What? The Office Policy Manual**  
**Joseph P. Graskemper,** DDS, JD, FCLM, DABMM

11:50-Noon  
**Networking Break** - Glass Oaks Ballroom

Noon - 1:15pm  
**Cyril Wecht Luncheon**  
This lecture made possible through a grant from the ACLM Foundation - Wedgwood Ballroom  
**Moderator:** Cyril H. Wecht, MD, JD, FCLM  
**Presenter:** Richard Adler, MD, Forensic & Clinical Psychiatry (110)  
(All attendees are invited with additional registration cost; this meal is not included in your registration fee.)

1:15 - 3:00pm

**DENTAL SESSION VI** - Brazos  
**Moderator:** Chester Gary, DDS, JD, FCLM

1:15 - 1:45pm  
**Substance Abuse in Dentistry & State Responses**  
**Nicholas Panomitrus,** DDS, JD, FCLM  
**Bruce Seidberg,** DDS, MScD, JD, FCLM

1:45 - 2:15pm  
**Telemedicine in Dentistry: An Overview and its Legal Considerations**  
**Bill Tham,** DDS, JD, FCLM

Numbers in parenthesis reference page numbers for available session handouts.  
All General and Breakout Sessions include a Q&A. Joint General Sessions include both Scientific and Dental Programs. Schedule subject to change.
Saturday, February 27 (continued)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:15 - 2:45pm</td>
<td><strong>Failure to Diagnose Oral Cancer and Other Pathologic Conditions of the Oral Cavity</strong> 220</td>
</tr>
<tr>
<td></td>
<td><em>Kalu Ogbureke, DDS, JD, FCLM</em></td>
</tr>
<tr>
<td>2:45 - 3:00pm</td>
<td><strong>General Q&amp;A — All Speakers &amp; Closing Remarks</strong></td>
</tr>
<tr>
<td>1:30 - 3:15pm</td>
<td><strong>Breakout Session IV: Terminally Ill Patients and Immigrants</strong></td>
</tr>
<tr>
<td></td>
<td><em>Grand Ballroom A</em></td>
</tr>
<tr>
<td></td>
<td>» Expedited Access and Expedited Approval Pathways for Biomedical Products: A Global Perspective (127)</td>
</tr>
<tr>
<td></td>
<td>» Medical Deportation: Legal and Ethical Issues (137)</td>
</tr>
<tr>
<td></td>
<td>» Prosecutorial Bias and Excessive Police Force (141)</td>
</tr>
<tr>
<td></td>
<td>» Q &amp; A</td>
</tr>
<tr>
<td></td>
<td><em>Moderator: John Conomy, MD, JD, FCLM</em></td>
</tr>
<tr>
<td></td>
<td><em>Panelists: Jack Snyder, JD, PhD, MPH, MSSA</em></td>
</tr>
<tr>
<td></td>
<td><em>Sana Loue, JD, PhD, MPH, MSSA</em></td>
</tr>
<tr>
<td></td>
<td><em>Cyril H. Wecht, MD, JD, FCLM</em></td>
</tr>
<tr>
<td>3:15 - 3:30pm</td>
<td><strong>Networking Break</strong></td>
</tr>
<tr>
<td></td>
<td><em>Glass Oaks Ballroom</em></td>
</tr>
<tr>
<td>3:30 - 4:45pm</td>
<td><strong>Sandy Sanbar Lecture (Ethics): Confronting Traumatic Brain Injury: Devastation, Hope, and Healing (149)</strong></td>
</tr>
<tr>
<td></td>
<td><em>Grand Ballroom A</em></td>
</tr>
<tr>
<td></td>
<td><em>William J. Winslade, PhD, JD, James Wade Rockwell Professor of Philosophy in Medicine, Institute for the Medical Humanities, University of Texas Medical Branch Galveston and Distinguished Visiting Professor of Law and Associate Director for Graduate Programs, University of Houston School of Law</em></td>
</tr>
<tr>
<td>4:45 - 6:30pm</td>
<td><strong>Annual Meeting of the Fellows</strong></td>
</tr>
<tr>
<td></td>
<td><em>Grand Ballroom A</em></td>
</tr>
<tr>
<td>6:30 - 7:00pm</td>
<td><strong>Networking Reception</strong></td>
</tr>
<tr>
<td></td>
<td><em>Glass Oaks Ballroom</em></td>
</tr>
</tbody>
</table>

Sunday, February 28

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 - 9:00pm</td>
<td><strong>Annual Awards and Networking Banquet:</strong> Patients, Our Most Vulnerable Population: Where Are We 15 Years After the Institute of Medicine Reports on Safety and Quality Improvement? (157) - Grand Ballroom A</td>
</tr>
<tr>
<td></td>
<td><em>Moderator: Thomas R. McLean, MD, MS, JD, FCLM</em></td>
</tr>
<tr>
<td></td>
<td><em>Presenter: Kenneth I. Shine, MD, MACP, Special Advisor to the Chancellor, University of Texas System</em></td>
</tr>
<tr>
<td></td>
<td>(All attendees are invited with additional registration cost; this meal is not included in your registration fee.)</td>
</tr>
</tbody>
</table>

**Sunday, February 28**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00am - 1:00pm</td>
<td><strong>Registration Desk</strong> - Grand Ballroom Foyer</td>
</tr>
<tr>
<td>7:00am - 1:00pm</td>
<td><strong>Poster Sessions</strong> - Glass Oaks Ballroom</td>
</tr>
<tr>
<td>7:00 - 8:00am</td>
<td><strong>Continental Breakfast</strong> - Glass Oaks Ballroom</td>
</tr>
<tr>
<td>8:00 - 9:15am</td>
<td><strong>General Session IV: Elders and the Uninsured</strong></td>
</tr>
<tr>
<td></td>
<td><em>Grand Ballroom A</em></td>
</tr>
<tr>
<td></td>
<td>» Granny Goes to Jail: Medicaid Eldercare Liability (164)</td>
</tr>
<tr>
<td></td>
<td>» Obamacare: Who Was Left Behind?</td>
</tr>
<tr>
<td></td>
<td>» The Role of Medical—Legal Partnerships in Helping Vulnerable Populations (168)</td>
</tr>
<tr>
<td></td>
<td>» Q &amp; A</td>
</tr>
<tr>
<td></td>
<td><em>Moderator: Alejandro Moreno, MBBS, MPH, JD, FACP, FCLM</em></td>
</tr>
<tr>
<td></td>
<td><em>Panelists: C. William Hinnant Jr., MD, JD, FCLM; Richard J. Kelly, MD, JD, MPH, FCLM; Keegan Warren-Clem, Attorney</em></td>
</tr>
<tr>
<td>9:15 - 9:30am</td>
<td><strong>Networking Break</strong></td>
</tr>
<tr>
<td></td>
<td><em>Glass Oaks Ballroom</em></td>
</tr>
</tbody>
</table>

Numbers in parenthesis reference page numbers for available session handouts.

All General and Breakout Sessions include a Q&A.

Joint General Sessions include both Scientific and Dental Programs.

Schedule subject to change.
THE ADHD Dysfunction and the Duty of Loyalty: Ethical Treatment Strategies for Compliance When Physicians Confront Increased Regulatory Scrutiny for Prescribing DEA Schedule 2 Treatments to Vulnerable Populations
Michael G. Anderson, MD, JD, FCLM, DABLM

The Ethics of Grateful Patient Programs
1LT Christin Burrows; MAJ Tom Collette; CPT John Heninger

Exploration the Ethical Considerations of the Army’s Assignment Policy for Soldiers Who Are HIV Positive
CPT Julian Gilbert; Kimberly Tansey, DPT; Capt. Gregory Taylor

The Ethical Use of Antibiotics
Aaron Harris, DC; Joel Neuenschwander; CPT Erik Wiesenhan

Physician Orders for Life-Sustaining Treatment (POLST)
Elizabeth Harris, MS, RD; LCDR Christina Lumba, USN, BSN, RN

Ethics in Film: An Example Using the Film, Bridge on the River Kwai
C. Scott Kruse, MBA, MSIT, MHA, PhD, FACHE; Karin W. Zucker, MA, JD, LLM, FCLM; Martin J. Boyle, JD

Optical Forensic Examination of Questioned Medical Record Documents
Danial Laird, MD, JD. FCLM

The Ethics of Allocating Experimental Treatment for the Ebola Virus
MAJ Kate Martinez; CPT Jessica Forman; CPT Kate Little

The Ethics of Direct-to-Consumer Advertising of Healthcare Services
CPT Jerry Moon; Ms. Cynthia Robertson; MAJ Sorquist

Adjusting for Risks under P4P Measures for Socioeconomic Factors
CPT Matt Moore; CPT Ino Ruiz; CPT Becky Lux, RN

Art Therapy and Hippotherapy: Effective Therapeutic Strategies That Are Not Covered Under the Affordable Care Act
Christine Pham; Robert Bitonte, MD, MA, JD, LLM, FCLM

Direct-to-Consumer Pharmaceutical Advertisement – Using the Army Baylor 7-Step Model Modified for Organizational, Ethical Decision-Making
MAJ Robert Shaw; Capt. Daniel Prather; ENS Jujuane Hairston

The Genetic Information Nondiscrimination Act of 2008: Applying the Army Baylor Organizational Decision-Making Model
LTC John Thomas, MC; CPT Seungho Kang; CPT Charles Wyatt

On Human Enhancement Technology: Expanding the Limits of Human Nature
Michael Vinluan, MD

The Misuse of ‘Stigmatization’ in Chronic Pain Patients
Lauren McLaughlin, DO; Keleigh McLaughlin MS-III; Ajay Vellore, MD; Rachael Rzasa-Lynn, MD
2016 ACLM 56TH ANNUAL MEETING
BOARD OF GOVERNORS 2015-2016

Officers

President - Thomas R. McLean, MD, MS, JD, FCLM
President-Elect - Daniel L. Orr, II, DDS, PhD, JD, MD, FCLM
Secretary - David Donnersberger, Jr., MD, JD, MA, FCLM
Treasurer - C. William (Bill) Hinnant, Jr., MD, JD, DABU, FCLM
Past President - Victoria Green, MD, JD, MBA, MHSA, FCLM

Board Members

Monique Anawis, MD, JD, FCLM
Eli Avila, MD, JD, MPH, FCLM
Joseph Graskemper, DDS, JD, FCLM
Weldon (Don) Havins, MD, JD, FCLM
Raymund King, MD, JD, FCLM
Alejandro Moreno, MD, MPH, JD, FCLM
Howard Morgan, MD, FCLM, FACS
Kalu Ogbureke, DDS, JD, DMSc FDSRCS, FRCPaH, FCLM
Howard S. Podolsky, MD, JD, MBA, FCLM
Veling W. Tsai, MD, JD, FCLM
Karin Waugh Zucker, MA, JD, LLM, FCLM

Ex-Officio

JLM Editor in Chief
Richard J. Kelly, MD, JD, FCLM
ABLM Chair
Peter H. Rheinstein, MD, JD, MS, FCLM, FAAFP
ACLM Foundation President
Robert W. Buckman, PhD, FCLM

Headquarer Office

Executive Director
Laurie Krueger, CAE

2015-2016 ACLM COMMITTEE LISTING

Education Council

Charles W. Hinnant, Jr., MD, JD, DABU, FCLM (Council Chair)

Education and Professional Development Committee
Alejandro Moreno, MBBS, MPH, JD, FCLM (Committee Co-Chair)
Daniel L. Orr, II, DDS PhD JD MD FCLM (Committee Co-Chair)
Monique Anawis, MD, JD, FCLM
David Donnersberger, Jr., MD, JD, MA, FCLM
Joseph Graskemper, DDS, JD, FCLM
Adam McLaughlin, MD, JD, FCLM
Steve Waxman, MD, JD, FCLM

CME Oversight Committee
Richard S. Wilbur, MD, JD, FCLM (Committee Chair)
Thomas R. McLean, MD, MS JD, FCLM
Steve Walter Waxman, MD, JD, FCLM

Poster Session Chair
Karin Waugh Zucker, MA, JD, LLM, FCLM

Student Awards Committee
John Adam McLaughlin, MD, JD, FCLM (Committee Chair)
Susan W. Balter, MD, JD, MPH, FCLM
Robert W. Buckman, PhD, FCLM
Mark J. Greenwood, DO, JD, FCLM
Dorothy Rasinski Gregory, MD, JD, FCLM
Cyrene Grothaus-Day, MD, JD, FCLM
Howard Morgan, MD, FCLM, FACS
Alejandro Moreno, MD, MPH, JD, FCLM
Kalu Ogbureke FRCPaH FCLM, DDS JD DMSc FDSRCS
Nicholas Panomitros, DDS, MA, JD, LLM, FCLM

Services Council

David Donnersberger, MD, JD, MBA, FCLM (Council Chair)

Directory and Website Committee
Robert W. Buckman, PhD, FCLM (Committee Chair)
Richard E. Fradette, BSPharm, JD, MPH
Veling W. Tsai, MD, JD, FCLM

JLM Editorial Board
Richard Kelly, MD, JD, FCLM (Editor)
David Donnersberger, MD, JD, MA, FCLM (Assistant Editor)
W. Eugene Basanta, JD, LLM
David Benjamin, PhD, FCLM
Christopher Burkle, MD, JD, FCLM
Gregg Cochran, MD, JD, FCLM
Dale Cowan, MD, JD, FCLM
Kate Diesfeld, BA, JD
Marvin Firestone, MD, JD, FCLM
Mark Fisher, MD, JD, FCLM
Michael G. Getty, JD
Alejandro Moreno, MBBS, MPH, JD, FCLM
Daniel Orr II, DDS, PhD, JD, MD, FCLM
Daniel Tennenhous, MD, JD, FCLM
Veling Tsai, MD, JD, FCLM
Jessica VanBeek (Student Editor)
ACLM 56th Annual Meeting Program Book

2016 ACLM 56th Annual Meeting

2015-2016 ACLM Committee Listing

Marketing & Public Relations Committee
Charles W. Hinnant, Jr., MD, JD, DABU, FCLM (Committee Chair)
Virginia Hinnant
Debra Petracca

Publications Committee
Charles W. Hinnant, Jr., MD, JD, DABU, FCLM (Committee Chair)
W. Eugene Basanta, JD, LLM
Gregg Cochran, MD, JD, FCLM
Theodore R. LeBlang, JD, FCLM

Ways and Means Council
Daniel L. Orr, II, DDS PhD JD MD FCLM (Council Chair)

Bylaws and Resolutions Committee
John Adam McLaughlin, MD, JD, FCLM (Committee Chair)
Charles W. Hinnant, Jr., MD, JD, DABU, FCLM

Ethics Committee (Amicus)
Cyrene Grothaus-Day, MD, JD, FCLM (Committee Chair)
W. Eugene Basanta, JD, LLM
Daniel J. Schwartz, MD JD MPH MBE LLM
Toan Foeng Tham, BA, DDS, JD, FCLM

Finance Committee
David Donnersberger, Jr., MD, JD, FCLM (Committee Chair)
Weldon Havins, MD, JD, FCLM
Deven P. Sharma, FCIS, LLB, CPA, TEP
Jack Snyder MD JD PhD MPH, MFS MBA MSIS FCLM

Membership Council
Victoria Green, MD, JD, MBA, MHSA, FCLM (Council Chair)

Honorary Fellowship & Gold Medal Committee
Dale Cowan, MD, JD, FCLM (Committee Chair)
Art Cohen, MD, JD, FCLM, MBA
Marvin Firestone, MD, JD, FCLM

Membership and Credentials Committee
Karin Zaner, JD, FCLM (Committee Chair)
Jonathan Fanaroff, MD, JD, FCLM (Committee Chair)
Richard E. Fradette, BSPharm, JD, MPH
Chester Gary, DDS, JD, FCLM
Kalu Ogbureke, FRCPaH, FCLM, DDS, JD, DMSc, FDSRCS
Matthias I. Okoye, MD, JD, FCLM
Noah D. Sabin, MD, JD, FCLM
Martin J. Stillman, MD, JD, FCLM
Veling W. Tsai, MD, JD, FCLM
Mary Jean Wall, MD, JD, FCLM
Thomas G. Walsh, DDS, JD, LLM, FCLM

Nominating Committee
Victoria Green, MD, JD, MBA, MHSA, FCLM (Committee Chair)
Cyrene Grothaus-Day, MD, JD, FCLM
Kalu Ogbureke, FRCPaH, FCLM, DDS, JD, DMSc, FDSRCS
Peter H. Rheinstein, MD, JD, MS, FCLM, FAAFP
Steve Waxman, MD, JD, FCLM

Judicial Council
Richard S. Wilbur, MD, JD, FCLM (Council Chair)
Arthur Cohen, MD, JD, MBA, FCLM
Dale Cowan, MD, JD, FCLM
Bruce Seidberg, DDS, MScD, JD, FCLM
Philip Shelton, MD, JD, FCLM

Special Councils
Thomas R. McLean, MD, MS, JD, FCLM (Council Chair)

ACLM Special Council
Charles W. Hinnant, Jr., MD, JD, DABU, FCLM (Committee Chair)
Eric Eglite, DPM, JD, MBA, MSc, BS, BA

AMA Delegates
Victoria Green, MD, JD, MBA, MHSA, FCLM
Richard S. Wilbur, MD, JD, FCLM

Policy Review Ad Hoc Committee
Joseph Graskemper, DDS, JD, FCLM (Committee Chair)
Bruce H. Seidberg, DDS, MScD, JD, FCLM
Toan Foeng Tham, BA, DRS, JD, FCLM
James Thomas, MD

National Health Law Moot Court Competition
W. Eugene Basanta, JD, LLM (Committee Chair)
Monique Anawis, MD, JD, FCLM
Francois M. Blauedau, MD, JD, FCLM, FACHE
Henry H. Chan, MD, JD, FCLM
David Donnersberger, Jr., MD, JD, FCLM
Charles R. Hollen, MD, JD, FCLM
Sana Loue, JD, PhD, MPH, MA
Alejandro Moreno, MD, MPH, JD, FCLM
Veling W. Tsai, MD, JD, FCLM
<table>
<thead>
<tr>
<th>Year</th>
<th>Name</th>
<th>Year</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>Thomas R. McLean, MD, MS, JD, FCLM</td>
<td>1983</td>
<td>* Jerry Zaslow, MD, JD, FCLM</td>
</tr>
<tr>
<td>2013</td>
<td>Victoria L. Green, MD, JD, MBA, MHSA, FCLM</td>
<td>1982</td>
<td>Edgar A. Reed, MD, JD, FCLM</td>
</tr>
<tr>
<td>2012</td>
<td>Kent E. Harshbarger, MD, JD, MBA, FCLM</td>
<td>1981</td>
<td>* James G. Zimmerly, MD, JD, MPH, LLD, FCLM</td>
</tr>
<tr>
<td>2011</td>
<td>Gary Birnbaum, MD, JD, FCLM</td>
<td>1980</td>
<td>* William H.L. Dornette, MD, JD, FCLM</td>
</tr>
<tr>
<td>2011</td>
<td>Dale H. Cowan, MD, JD, FCLM</td>
<td>1979</td>
<td>* Richard F. Gibbs, MD, LLB, JD, FCLM</td>
</tr>
<tr>
<td>2010</td>
<td>Melvin A. Shiffman, MD, JD, FCLM</td>
<td>1978</td>
<td>John S. Boyden, MD, JD, FCLM</td>
</tr>
<tr>
<td>2009</td>
<td>Michael M. Raskin, MD, JD, MS, MPH, MA, MBA, FCLM</td>
<td>1977</td>
<td>John S. Boyden, MD, JD, FCLM</td>
</tr>
<tr>
<td>2008</td>
<td>Bruce H. Seidberg, DDS, MScD, JD, FCLM</td>
<td>1976</td>
<td>Don Harper Mills, MD, JD, FCLM</td>
</tr>
<tr>
<td>2007</td>
<td>Richard S. Wilbur, MD, JD, FCLM</td>
<td>1975</td>
<td>Don Harper Mills, MD, JD, FCLM</td>
</tr>
<tr>
<td>2006</td>
<td>Philip A. Shelton, MD, JD, FCLM</td>
<td>1974</td>
<td>Monroe E. Trout, MD, JD, LLB, FCLM</td>
</tr>
<tr>
<td>2005</td>
<td>Theodore R. LeBlang, JD, FCLM</td>
<td>1973</td>
<td>Monroe E. Trout, MD, JD, LLB, FCLM</td>
</tr>
<tr>
<td>2004</td>
<td>* Philip S. Cifarelli, MD, JD, FACP, FCLM, FACG</td>
<td>1972</td>
<td>Cyril H. Wecht, MD, JD, FCLM</td>
</tr>
<tr>
<td>2003</td>
<td>Miles J. Zaremski, JD, FCLM</td>
<td>1971</td>
<td>Cyril H. Wecht, MD, JD, FCLM</td>
</tr>
<tr>
<td>2002</td>
<td>Fillmore Buckner, MD, JD, FCLM</td>
<td>1970</td>
<td>Cyril H. Wecht, MD, JD, FCLM</td>
</tr>
<tr>
<td>2001</td>
<td>Jack W. Snyder, MD, JD, MPH, PhD, FCLM</td>
<td>1969</td>
<td>* Carl E. Wasmuth, MD, LLB, FCLM</td>
</tr>
<tr>
<td>2000</td>
<td>Edward David, MD, JD, FCLM</td>
<td>1968</td>
<td>* Carl E. Wasmuth, MD, LLB, FCLM</td>
</tr>
<tr>
<td>1999</td>
<td>John Alexander Anderson, MD, JD, FCLM</td>
<td>1967</td>
<td>* Carl E. Wasmuth, MD, LLB, FCLM</td>
</tr>
<tr>
<td>1998</td>
<td>Martin B. Flamm, MD, JD, FCLM</td>
<td>1966</td>
<td>* Charles U. Letourneau, MD, LLB, FCLM</td>
</tr>
<tr>
<td>1997</td>
<td>* Stewart R. Reuter, MD, JD, FCLM</td>
<td>1965</td>
<td>* Charles U. Letourneau, MD, LLB, FCLM</td>
</tr>
<tr>
<td>1996</td>
<td>Arthur J. Cohen, MD, JD, FCLM</td>
<td>1964</td>
<td>* Charles U. Letourneau, MD, LLB, FCLM</td>
</tr>
<tr>
<td>1995</td>
<td>Allan Gibofsky, MD, JD, FCLM</td>
<td>1963</td>
<td>* Louis J. Gelber, MD, LLB, FCLM</td>
</tr>
<tr>
<td>1994</td>
<td>Marvin H. Firestone, MD, JD, FCLM</td>
<td>1962</td>
<td>* Maurice B. Shure, MD, FCLM</td>
</tr>
<tr>
<td>1993</td>
<td>* Daniel B. Cullan, MD, JD, FCLM</td>
<td>1961</td>
<td>* Rueben M. Dicker, MD, LLM, FCLM</td>
</tr>
<tr>
<td>1992</td>
<td>Charles R. Hollen, MD, JD, FCLM</td>
<td>1991</td>
<td>John R. Carlisle, MD, LLB, FCLM</td>
</tr>
<tr>
<td>1990</td>
<td>S. Sandy Sanbar, MD, PhD, JD, FCLM</td>
<td>1989</td>
<td>* Harold L. Hirsh, MD, JD, FCLM</td>
</tr>
<tr>
<td>1988</td>
<td>Lee S. Goldsmith, MD, LLB, FCLM</td>
<td>1987</td>
<td>Sal Fiscina, MD, MD, FCLM</td>
</tr>
<tr>
<td>1986</td>
<td>Dorothy Rasinski-Gregory, MD, JD, FCLM</td>
<td>1985</td>
<td>Francis I. Kittredge, Jr., MD, JD, FCLM</td>
</tr>
<tr>
<td>1984</td>
<td>* Arthur H. Coleman, MD, JD, FCLM</td>
<td>1983</td>
<td>* Jerry Zaslow, MD, JD, FCLM</td>
</tr>
</tbody>
</table>

* Deceased
GOLD MEDAL AWARD RECIPIENTS

2015  Robert W. Buckman, PhD, FCLM
2014  Dale H. Cowan, MD, JD, FCLM
2013  Bruce H. Seidberg, DDS, MScD, JD, FCLM
2012  Stewart Reuter, MD, JD, FCLM
2011  No Medal Awarded
2010  Richard S. Wilbur, MD, JD, FCLM
2009  Marshall B. Kapp, JD, MPH, FCLM
2008  Philip S. Cifarelli, MD, JD, FCLM, FACP, FACG
2008  Marvin H. Firestone, MD, JD, FCLM
2007  Theodore LeBlang, JD, FCLM
2006  W. Eugene Basanta, JD, LLM
2005  Fillmore Buckner, MD, JD, FCLM
2004  Arnold “Skip” Rosoff, JD, FCLM
2004  Sal Fiscina, MD, JD, FCLM
2003  Peter Rheinstein, MD, JD, MS, FCLM, FAAFP
2002  Richard Gibbs, MD, LLB, JD, FCLM (posthumous)
2001  Ed Hollowell, JD, FCLM
2001  Richard Tyler, MD, JD, FCLM
2000  Sandy Sanbar, MD, JD, PhD, FCLM
2000  Lee S. Goldsmith, MD, LLB, FCLM
1999  No Medal Awarded
1998  Donald Harper Mills, MD, JD, FCLM
1998  Monroe Trout, MD, JD, LLB, FCLM
1997  James Zimmerly, MD, JD, MPH, LLD, FCLM
1997  Harold L. Hirsh, MD, JD, FCLM
1996  Cyril H. Wecht, MD, JD, FCLM
1996  Dorothy Rasinski-Gregory, MD, JD, FCLM

HONORARY FELLOWS
Since 2000

Lori B. Andrews, JD, FCLM
George J. Annas, JD, MPH
Michael M. Baden, MD
Arthur Caplan, PhD
Amnon Carmi, MA
Mitchell D. Forman, DO, FACP, FACOI, FAC, FCLM
Carol Henderson, JD
Henry C. Lee, PhD

Connie Mariano, MD
Bill McCollum, JD
David T. Ozar, PhD, FCLM
Karen H. Rothenberg, JD, MPA
William M. Sage, MD, JD, FCLM
Barry C. Scheck
Carl E. Schneider, JD
Nicolas P. Terry, BA, FCLM
Richard Adler, MD, is a high profile forensic & clinical psychiatrist. Apropos of being tapped for this event, in medical school Rich got top honors in Pathology. This prompted him to spend a year in Dr. Ramzi Cotran's Department of Pathology at Harvard/Brigham and Women's Hospital. Rich completed his Adult & Child/Adolescent Psychiatry training at Harvard/ Massachusetts General Hospital, and a Forensic Psychiatry Fellowship at the University of Washington in Seattle. Rich has made good use of his interest in pathology-based Psychiatry as founding Medical Director of Fetal Alcohol Spectrum Disorder Experts (www.FASDExperts.com), a pioneering group in the forensic applicability of FASD to criminal culpability -- especially in Death Penalty cases in over fifteen states since 2007. Rich has been actively involved in the use of Quantitative Electroencephalography, MRI, DTI and PET in both criminal and civil cases. Rich owes a deep debt of gratitude to Dr. Cyril Wecht for his important role in the recent and ongoing revisiting of the 1959 Kansas Clutter Family Murders, upon which Truman Capote's In Cold Blood is based. Rich's manuscript The Real Cold Blood awaits the hand (and red pencil) of a good editor.

Mert N. Aksu, DDS, JD, MHSA, FCLM, Professor, Department of Patient Management. Mert N. Aksu was named Dean of the University of Detroit Mercy School of Dentistry on July 1, 2008. At the UDM School of Dentistry, he served as a faculty member and administrator since 1993.

Aksu earned a BS in Biological Sciences and Psychology from the University of Michigan Dearborn, DDS from the University of Michigan School of Dentistry, and a JD from Wayne State University, and a Master's in Health Services Administration from the University of Michigan. Aksu is a former attending staff of Henry Ford Health Systems, a member of the State Bar of Michigan, and is a Fellow with the American College of Legal Medicine. Aksu earned a BS in Biological Sciences and Psychology from the University of Michigan Dearborn, DDS from the University of Michigan School of Dentistry, and a JD from Wayne State University, and a Master's in Health Services Administration from the University of Michigan. Aksu is a former attending staff of Henry Ford Health Systems, a member of the State Bar of Michigan, and is a Fellow with the American College of Legal Medicine. Aksu earned a BS in Biological Sciences and Psychology from the University of Michigan Dearborn, DDS from the University of Michigan School of Dentistry, and a JD from Wayne State University, and a Master's in Health Services Administration from the University of Michigan. Aksu is a former attending staff of Henry Ford Health Systems, a member of the State Bar of Michigan, and is a Fellow with the American College of Legal Medicine.

Throughout his career, Aksu began a number of activities to further the mission of UDM and the school. He was the founding chairperson of the Department of Patient Management, enhanced community outreach opportunities, and fostered an environment of patient care, based on a comprehensive care model.

Through strong collaboration with faculty and staff, the School strengthened the delivery of oral health care and implemented a state-of-the-art electronic patient record system. Dr. Aksu was responsible for creating the vision for what is today the new location of the School at the Corktown Campus on Martin Luther King Drive.

Dean Aksu has helped position the dental school for strong growth in educating additional dental professionals and providing care for more patients who are underserved. The School of Dentistry recently received a successful CODA review of its plan to increase class size from 98 to 144 and UDM is currently in the third year of its class expansion.

Up until June of 2012, Dr. Aksu maintained a private practice in general dentistry with an emphasis on adult comprehensive care. Dr. Aksu serves on the Board of Managers and is a Member of the Doctors’ Advisory Panel of Great Expressions Dental Centers, a privately held dental group owned by the Ontario Municipal Employees Retirement System.

Monique A. Anawis, MD, JD, FCLM, is the Medical Director for the Office of the Illinois Attorney General [OAG] Lisa Madigan. As the Medical Director and an Assistant Attorney General, she works with attorneys and mediators in the OAG’s Health Care Bureau on consumer investigations and appeals, the Consumer Fraud Bureau on pharmaceutical and device cases, and the Special Prosecutions Bureau on criminal investigations and prosecutions. Additionally, Dr. Anawis works on OAG matters of policy and legislation, general law, healthcare fraud, and veterans’ benefits. She is a practicing board-certified ophthalmic surgeon, fellow of the American Academy of Ophthalmology, fellow of the Institute of Medicine, and a fellow and member of the Board of Governors of the American College of Legal Medicine. She is an Assistant Professor of Clinical Ophthalmology at Northwestern University Feinberg School of Medicine, and a clinician and lecturer for the medical residency program at Weiss Memorial Hospital. She was the vice president of her hospital medical staff and a member of the peer review and credentials committees and co-chair of the medical executive board. As a magna cum laude graduate of Brown University, she also earned her medical degree with honors from Brown University Alpert School of Medicine and serves as a member and secretary of the Brown University Alumni Medical Board. As past chair and member of the Blindness Prevention Task Force of the NGO and Vision 2020 partner, Health For Humanity, Dr. Anawis has lectured and continues to instruct and collaborate with physicians in the U.S., Mongolia and Europe.

Dr. Anawis has served as the Chair of the Health Care Section Council of the Illinois State Bar Association and its health care legislation subcommittee. She is a member of the American Health Lawyers Association Alternative Dispute Resolution panel and the American Bar Association Health Care Section. She has served on the Ethics, Education and National Health Law Moot Court Committees of the American College of Legal Medicine.
Dr. Anawis has served as an Adjunct Professor of Health Law at John Marshall Law School in Chicago. She graduated from DePaul Law School with honors and a Certificate of Health Law. A key goal of Dr. Anawis’s dual careers in law and medicine is to communicate and clarify the complexities of healthcare to her fellow physicians, attorneys and the public. She is a lecturer, trained mediator, consultant and attorney to physicians, health care providers, institutions and fellow attorneys both nationally and internationally focusing on medical malpractice, medical staff/hospital matters, regulatory matters, ethics, health policy and U.S. health care reform.

Eli N. Avila, MD, JD, MPH, FCLM. The Honorable Eli Narciso Avila currently serves as the 9th Commissioner of Health for Orange County, NY. In this current public health executive role, he presides over the health and welfare of Orange County’s approximately 400,000 diverse citizens and manages a $67 million dollar budget. Since his arrival in Orange County, the New York State Bar has appointed him to the Committee for Mass Disaster Response and he is an active member of the Public Health Law Section, where he has collaborated on three webinars to assist the New York State Legislature as it adapts legislation to conform to the merger of primary care and traditional public health under the Affordable Care Act. Currently, he is addressing health outcomes by confronting chronic health issues such as diabetes and hypertension, by tackling childhood obesity, by increasing childhood immunization rates, by removing health disparities, by increasing efficient linkages to care, and by increasing screening for Hepatitis C among baby boomers.

Prior to this position, he served as the 26th Secretary of Health of the Commonwealth of Pennsylvania managing a $1 billion budget and a staff of 1,700. He received unanimous bipartisan Senate confirmation. Dr. Avila was the first Latino in the state’s history to hold this cabinet position. As Secretary, Dr. Avila was the top health regulator in Pennsylvania, the senior health policy advisor to the executive branch and served as a liaison to the Governor and the US Dept. of Health and Human Services for the Pennsylvania Department of Health. During his tenure he was instrumental in the authoring and passage of sixteen health related laws, was the first state health official in the country to provide testimony and a detailed national health education and epidemiological surveillance plan for communities near Marcellus Shale Hydraulic Fracturing activities, removed regulatory obstacles to mobile lab testing and rapid HIV/Hepatitis C screening, provided updated/uniform Hospital Accreditation and EMS Regulations, and addressed disparity issues by holding Pennsylvania’s first statewide Health Equity Conference and by facilitating telemedicine into isolated rural areas.

Prior to this role, Dr. Avila served as the Chief Deputy Commissioner of Health Services and Director of Public Health for Suffolk County, NY, the seventh largest county in the US, where he managed a $400 million budget and a staff of 1,400. As a physician-attorney, Dr. Avila has held a variety of roles of diverse scope and responsibility including: Senior Examining Occupational Medicine Physician for federal agents in Albany, NY, Associate General Counsel for an environmental biotechnology company, Law Associate for an intellectual property law firm, Clinical Instructor in Ophthalmology and Surgical Attending at Columbia University, and Medical Director of an ophthalmology practice where he performed emergency eye trauma surgery and corneal transplant surgery.

In 2012, Dr. Avila graduated from the prestigious National Preparedness Leadership Initiative, a joint program between the Harvard Kennedy School of Government and the Harvard School of Public Health. In 2011, he completed the highly exclusive Executive Education program for State Health Officials at the Harvard School for Public Health. His academic pedigree includes graduating from Phillips Academy as a full scholarship student under the “A Better Chance” program, an ScB in Biology from Brown University, an MD from the Brown Medical School, a JD with cum laude honors from the St. John’s University School of Law, and an MPH with highest honors from the Mount Sinai School of Medicine.

Ruth Berggren, MD, FACP, Professor of Medicine and Director, Center for Medical Humanities and Ethics, University of Texas Health Science Center San Antonio

Paul Blaylock, MD, JD, FCLM, graduated valedictorian from the University of Tennessee while serving as Student Government President. Dr. Blaylock then graduated with highest honors from University of Tennessee Medical School (AOA) and Northwestern L&C Law School. He practiced Emergency Medicine/Trauma Centers for 35 years, Medical Director Providence Urgent Care, and now Private Practice Acute Injury/Trauma Clinic. He practiced for 30 years as a trial lawyer defending doctors/hospitals.

Dr. Blaylock’s ACLM Honors include: Board of Governors; President’s Award; Jefferson Cup Award. His UT Honors include: Outstanding Medical Alumnus Award UT Medical Bd. of Governors.

He has been a lecturer for over 75 cruises to 48 countries for International Conferences, University at Sea, and ACLM over the past 25 years. Lecturer: ACLM and ACEP.

Dr. Blaylock is a Medical Consultant for OrphansOverseas/Kenya, Amer. Red Cross Disasters and many other charitable organizations.
Dan W. Bolton, III, DC, DO, JD, LLM, FCLM, is an Attorney and Physician. He practices law at Bolton Law, P.L.L.C. in Cary, North Carolina and has an additional client support office near Washington, D.C. Attorney Bolton’s law practice focuses on appellate, intellectual property, and health care law to include vaccine injury claims. Dr. Bolton actively practices locum emergency medicine in several states and is a board-certified family physician.

Mitchell D. Forman, DO, MACP, FCLM is a practicing rheumatologist and Dean of the Touro University Nevada College of Osteopathic Medicine in Henderson, Nevada. He is Certified by the American Board of Osteopathic Internists and the American Board of Rheumatology. He has been selected a Master of the American College of Physicians. Currently, his serves as the president of the Nevada State Medical Association. Dr. Forman was instrumental in developing a curriculum in medical jurisprudence, ethics, and professionalism. In collaboration with the UNLV School of Theater Arts, he has produced filmed ethics issues vignettes which are being used around the globe.

Mary Lou Gaeta, MD, JD, FCLM, is a Pediatrician specialized in Pediatric Critical Care Medicine and a designated Senior Fellow in Hospital Medicine. She is Chief of the Section of Pediatric Hospital Medicine at Yale New Haven Children’s Hospital @ Bridgeport campus, and Assistant Clinical Professor of Pediatrics at Yale University School of Medicine. Dr. Gaeta is also Medical Director of KidEase, the Pediatric Procedural Sedation Program she established to provide safe practices for managing anxiety and pain for children undergoing medical procedures. She is interested in the intersection of Law, Medicine and Ethics and recently earned her JD degree from the University of Connecticut Law School. She serves on the Pediatric Ethics Committee at Yale New Haven Children’s Hospital and the Medical Ethics Committee at Bridgeport Hospital. Dr. Gaeta serves pro bono as Guardian Ad Litem for Children in Placement. She also has an interest in Global Health and has volunteered with various international medical relief programs in Uganda, Haiti, Jamaica, Thailand, and most recently in American Samoa.

Chester J. Gary, DDS, JD, FCLM, is an attorney at law, admitted in New York and Florida, with a practice concentrated on issues related to health care providers. He represents dentists and physicians in practice acquisitions and mergers, partnership formation, employment agreements, and dentists, personally, in malpractice litigation. He serves as a member of the New York State Dental Association (NYSFDA) Attorney Referral Panel and District Chair of the NYSFDA Professional Liability Claims Committee, which reviews dental malpractice claims in the eight counties of Western New York. He is Clinical Assistant Professor and Course Director of Practice and Risk Management, University at Buffalo School of Dental Medicine, author and certified presenter of the New York State mandated Dental Ethics and Jurisprudence Course, and is in the part-time private practice of general dentistry. Dr. Gary is also Editor of the Eighth District Dental Society Bulletin, Reviewing Editor of the Journal of the American Dental Association and New York State Dental Journal, fellow of the American College of Legal Medicine and American College of Dentists, and member of the Erie County, New York and Florida Bar Associations.

John Goldenring, MD, MPH, JD, FCLM

Joseph P. Graskemper, DDS, JD, FCLM, DABMM, currently practices full-time in Bellport, New York and is an Associate Clinical Professor at Stony Brook School of Dental Medicine, teaching professionalism, ethics, and risk management. He was the Past Director of Professional Responsibility courses and Past Editor in Chief of the Stony Brook School of Dental Medicine GPR Literature Review Journal. He has been awarded 6 Fellowships: Academy of General Dentistry, American Endodontic Society, International Congress of Oral Implantologists, American Society of Osseointegration, American College of Legal Medicine and American College of Dentists. He is also a Diplomat in the American Board of Legal Medicine, and has a law degree. He is a Board member of the International Dental Ethics and Law Society, American College of Legal Medicine, and the Suffolk County Dental Society. He also provides practice management consulting and expert witness testimony. He belongs to many professional organizations, and has served as a consultant to several State Dental Boards. Dr. Graskemper has authored many peer-reviewed articles, lectured and published nationally and internationally and recently published a book: “Professional Responsibility in Dentistry: A Guide to Law and Ethics”. He may be reached at jgraskemperdds@optonline.net for comments or consultations.

Richard S. Harold, DMD, JD, FCLM, is an Associate Clinical Professor and Practice Coordinator in the Department of Diagnosis and Health Promotion. Dr. Harold, a Massachusetts native, owned and operated a general dentistry practice in Malden for over 25 years before joining the Tufts faculty. He received his BS degree from Massachusetts College of Pharmacy in 1975, and his DMD degree from Tufts University School of Dental Medicine in 1980. Dr. Harold is also an attorney and received his JD from New England School of Law in 1995. He is a member of the Massachusetts Bar. Dr. Harold has developed and participated in several dental public health programs. He helped establish a dental clinic in Flores, Honduras, where he has visited over the years providing dental services to residents. Within the Malden Public Schools, Dr. Harold provided a dental screening and educational program to grade school students. Dr. Harold holds membership in the American Dental Association,
American Dental Education Association and the Massachusetts Dental Society. He is a Fellow of the American College of Legal Medicine. Dr. Harold has a specific interest in dental-legal issues and is a consultant in the areas of dental record keeping, documentation, prescription writing, regulatory issues, dental negligence and standards of care. He has lectured locally and nationally and has published several dental-legal articles.

Weldon (Don) Havins, MD, JD, FCLM, is In-House Counsel for Touro University Nevada where he is also Professor of Medical Jurisprudence, Professor of Ophthalmology and Associate Dean for Clinical Initiatives. Don is a Fellow of ACLM, is certified by the ABLM, and is a member of the Board of ACLM.

Katherine A. Hawkins, MD, JD, FCLM, received her medical degree from Columbia University College of Physicians and completed her residency training in Primary Care Internal Medicine at Roosevelt Hospital and her Hematology fellowship at New York University, both in New York City. Following medical training, she practiced Hematology and Internal Medicine and served as Assistant and Associate Residency Program Directors at St. Luke's and Beth Israel Medical Centers. She received her J.D. Degree from Fordham School of Law in 2002. Upon completing her law degree, she worked as an Associate Attorney for the firm of Gair, Gair, Conason, Steigman & Mackauf. In 2008 she joined the New York State Department of Health as a Medical Coordinator for the Office of Professional Medical Conduct and in 2009 was appointed Executive Secretary for the Board of Profession Conduct. She is a Fellow of the American College of Legal Medicine and the American College of Physicians, and an Associate Clinical Professor of Medicine, Division of Hematology and Medical Oncology, Icahn Mount Sinai School of Medicine. She is admitted to practice before the Bars of the State of New York and the Southern and Eastern Districts.

Margaret Hill, DMD

C. William Hinnant, Jr., MD, JD, FCLM, DABU, is the Principal in the firm Medicolegal Consultants, LLC and is a practicing Urologist.

His legal practice focuses on Health Litigation, White Collar Crime, Medical Malpractice, Personal Injury, Licensing, Peer Review and Credentialing Issues, Workers Compensation, ERISA Litigation and Insurance Law. He has authored Amicus Briefs for the College and other various health-related organizations as well as regulatory comments and is a member of the Bar of the United States Supreme Court. He has handled various appellate matters in both federal and state courts and continues to see patients as well, his interests including oncology, microsurgery and uroscopy. He is involved in his state’s “Lawyers Helping Lawyers” program for recovering professionals.

Bill is a member of the ACLM Board of Governors, its Counsel Chair and Corporate Counsel, and is also a member of the World Association for Medical Law. He and his wife Virginia have four grown children, are self-described “political junkies” and enjoy traveling, the arts, sports, gardening, cooking and their dachshund, June Bug (although June Bug can sometimes be hard to enjoy). They are annual participants in the Renaissance Weekend program organized by Former President Bill Clinton and encourage all ACLM members with an interest to consider joining them there.

S. Claiborne Johnston, MD, PhD. Since March 2014, Clay Johnston has served as the inaugural Dean of the Dell Medical School at The University of Texas at Austin. His ambitious vision includes building a world-class medical school by creating a vital, inclusive health ecosystem that supports new and innovative models of education, health care delivery and discovery – all with a focus on improving health and making Austin a model healthy city. He is also a neurologist, specializing in stroke care and research.

Previously, Clay was associate vice chancellor for research at the University of California, San Francisco, one of the nation’s leading health science centers.

He also directed the university’s Clinical and Translational Science Institute, overseeing the planning, development, and implementation of a $112-million, five-year, National Institutes of Health (NIH) grant award; and founded the UCSF Center for Healthcare Value to engage faculty and trainees in improving the quality of care while also lowering costs.

Richard J. Kelly, MD, JD, MPH, FCLM, is a member of the clinical faculty at the University of California in Irvine, California. He studied biochemistry and religion as an undergraduate at Harvard University before going on to study Public Health at U.C. Berkeley and both Medicine and Law at Stanford University. He completed his medical internship, anesthesiology residency, and fellowship in cardiothoracic anesthesiology at UCSF in San Francisco. He currently teaches cardiothoracic anesthesiology at the UCI Medical Center and public policy at the Health Policy Research Institute on the main UCI campus. His clinical interests focus on the anesthetic management of patients with complex cardiothoracic diseases and his research interests include the societal consequences of the Patient Protection and Affordable Care Act; ethical and legal implications of physician fatigue; and national trends in medical malpractice awards.
Gretchen E. Leach, JD, is a member of Nossaman’s Healthcare Practice Group. She represents individual practitioners, medical staffs, and other healthcare entities in a variety of proceedings, including medical staff peer review, licensing issues, administrative issues, regulatory matters, and litigation.

Prior to working at Nossaman, Ms. Leach represented the California Department of Health Care Services (DHCS) in complex administrative litigation involving Medi-Cal provider audit appeals, special education due process hearings, Community Based Adult Services (CBAS) hearings, and various personnel matters. She also advised the Department regarding conflict of interest code compliance, service contracts, employment law, and other regulatory matters.

William G. Leffler, DDS, JD, FCLM

Sana Loue, JD, PhD, MPH, MSSA, is a professor in the Department of Bioethics of Case Western Reserve University School of Medicine. She holds secondary appointments in Psychiatry, Epidemiology and Biostatistics, and Global Health and the Mandel School of Applied Social Sciences (social work) and serves as the Vice Dean for Faculty Development and Diversity of the School of Medicine. Dr. Loue holds degrees in law (JD), epidemiology (PhD), medical anthropology (PhD), social work (MSSA), secondary education (MA), public health (MPH) and theology (MA). Prior to joining the faculty of Case Western Reserve University School of Medicine, she practiced immigration and AIDS law. She has conducted research domestically and internationally, focusing on HIV risk and prevention, severe mental illness, family violence, immigrant health, and research ethics. She has authored or edited more than 30 books and more than 100 peer-reviewed journal articles. Dr. Loue serves as the editor-in-chief of the Journal of Immigrant and Minority Health and is a member of various editorial boards for peer review journals, including the Journal of Legal Medicine.

Darren P. Mareiniss, MD, JD, MBe, is a cum laude graduate of Dartmouth College, where he received an A.B. in Genetics and Developmental Biology. He received his M.D. from New York University School of Medicine, where he was a member of the Alpha Omega Alpha Honor Medical Society. Dr. Mareiniss also received a law degree from the University of Pennsylvania Law School and a Master’s of Bioethics from the University of Pennsylvania School of Medicine. He completed his residency training in Emergency Medicine at The Johns Hopkins Hospital, where he focused on critical care during his 4th year and received the outstanding resident research award.

Prior to joining MedStar, Dr. Mareiniss was full-time faculty at the University of Maryland Department of Emergency Medicine and practiced at Mercy Medical Center in Baltimore. Currently, Dr. Mareiniss is an attending physician in the Department of Emergency Medicine at MedStar Franklin Square Medical Center and a Clinical Instructor in the Department of Emergency Medicine at the University of Maryland School of Medicine. He has published and lectured extensively on various topics including: medico-legal issues, bioethics, defensive medicine, disaster preparedness, influenza, surveillance, crowding, end-of-life decision making and ICU triage. When not working, he enjoys spending time with his wife and two sons.

Leonard Morse, DDS, has 42 years of clinical experience spanning both private practice and hospital dental medicine. He holds combined BS/DDS degrees from NYU and is a life member of the ADA and the New York State Dental Association. He is a fellow of the International College of Dentists. He previously served as attending-in-charge of pediatric dentistry at Maimonides Medical Center and currently is section chief of restorative dentistry at New York Methodist Hospital.

In 2006, Dr. Morse was indicted on “B” Felony health care fraud charges. During a successful nine-year legal odyssey, Dr. Morse proved that his indictment was procured by evidence willfully fabricated by government officials.

A subsequent Federal civil rights lawsuit resulted in a 7.7 million dollar jury verdict in 2013, the 23rd largest verdict in that year.

He has previously spoken in New Orleans at the annual convention of the American Association of Dental Editors. He has also lectured on jurisprudence issues at UNLV.

Dr. Morse’s presentation will tell the story of an innocent healthcare provider who becomes ensnared in the justice system exclusively for political expediency. His experience is a real life David v. Goliath struggle.

Kalu Ogbureke, FRCPaH, FCLM, DDS, JD, DMSc, FDSRCS, is Professor and Chair of the Department of Diagnostic and Biomedical Sciences, University of Texas School of Dentistry at Houston. Professor Ogbureke graduated BDS, University of Ibadan, Nigeria; MSc, University of Glasgow; JD, Suffolk University Law School, Boston; Doctor of Medical Sciences (DMSc), Harvard University; and a Graduate Certificate in the Business of Medicine from Johns Hopkins University. He earned the Fellowship in Dental Surgery of the Royal Colleges of Surgeons of England, Glasgow, and Edinburgh (FDSRCS, FDSRCPs, FDSRCSEd). Professor Ogbureke also earned the Fellowship of the Royal College of Pathologists (FRCPath) of the United Kingdom. He has been elected to the Fellowship of the American College of Dentists (FACD), is a Fellow of the American College of Legal Medicine, and a Diplomate of the American Board of Medical Malpractice (ABMM). Professor Ogbureke is an oral and maxillofacial pathologist and a diplomate of the
American Board of Oral & Maxillofacial Pathology (ABOMP). His biomedical research is in the field of oral cancer. As an attorney, Professor Ogbugeke's interests are in Health Law and Policy, and Forensic Odontology.

**Daniel L. Orr II, BS, DDS, MS (anesthesiology), PhD, JD, MD, FCLM**, is an Oral & Maxillofacial Surgeon (OMS) practicing in Las Vegas, NV, is married and the father of nine children. He was named 1968 Eagle Scout of the Year by the Los Angeles Area Council and as an adult was awarded the Silver Beaver by the Boulder Dam Area Council. After graduating cum laude from BYU and with honors from USC School of Dentistry, he completed residencies in Anesthesiology at the University of Utah MC, where he also earned an MS in Anesthesiology, and in OMS at LA County/USC/MC. Dr. Orr then obtained a PhD in Biophysics from Columbia Pacific University. Dr. Orr subsequently graduated from William Howard Taft University School of Law and the University of Health Sciences Antigua School of Medicine. Dr. Orr is a Diplomate of the American Dental Board of Anesthesiology, the American Board of OMS, and the American Board of Legal Medicine. He has treated over 2,000 facial fractures and administered over 50,000 anesthetics. Dr. Orr has been on the founding boards of an off-shore professional liability insurance company, a 501(c)(3) approved public charity, and an FDIC approved bank. Dr. Orr is Professor and Director of OMS and Anesthesiology at the UNLV School of Dental Medicine and was selected the National Outstanding OMS Educator by AAOMS in 2011. He is a Clinical Professor of Anesthesiology and Surgery at the University of Nevada School of Medicine, and teaches high school and college level religious courses for The Church of Jesus Christ of Latter Day Saints. He is the Editor of the *NV Dental Association Journal*, Past President of the American Association of Dental Editors and Journalists, a member of several professional editorial boards and reviews articles for JOMS, JADA, OOOOE, JACD, and others. Dr. Orr is the Post-Mortem Coordinator for Nevada’s USPHS National Disaster Medical System, Chairman of the NSSOMS Anesthesia Committee, Past President of the NSSOMS, and is a Surveyor for the AAAHC. He is admitted to the CA Bar and the U.S. Ninth Circuit Court of Appeals. Dr. Orr is a member of the Sports Medicine Teams for UNLV Athletics, the AAA Pacific Coast League Las Vegas 51’s, the PRCA National Finals Rodeo, Past President of the D.A.R.E. Community Board, and the Medical Advisor and a Senior Patroller for the Las Vegas Area National Ski Patrol.

**Nicholas Panomitus, DDS, JD, FCLM**

**Leeann Podruch, DDS, JD,,** is a graduate of Marquette University School of Dentistry and Vermont Law School and has practiced dentistry for forty years and law for eighteen years. Dr. Podruch served on the Vermont State Board of Dental Examiners as both Secretary and Chair. She is a member of the Commission on Dental Competency Assessments (formerly the North East Regional Board of Dental Examiners, Inc.) for thirty years where she also served on the Board of Directors as Member-at-Large and Secretary. She enjoys administering clinical licensure exams for CDCA and has served as Chief, Assistant Chief, Captain and as an examiner for numerous exams where she is able to utilize both her dental and legal skills. Dr. Podruch served as Chair of the ADA Joint Commission on National Dental Examinations. She clerked with the Vermont Supreme Court after graduation from law school and is licensed to practice law in Vermont. She continues to practice clinical dentistry.

Aside from her professional involvements, Dr. Podruch is involved in lake stewardship projects in Wisconsin in maintaining and improving lake health for future generations and is Vice-President of the lake association affiliated with the lake where she and her husband reside.

**Frank J. Riccio, DMD, JD, FCLM,** has maintained a private law practice in Braintree, MA since 1987. He has substantial jury trial experience in civil litigation. His areas of concentration include medical and dental negligence; trucking liability; liquor liability; general negligence; and crime victim representation. Mr. Riccio has been a clinical instructor in Oral Medicine at Harvard Dental School since 1995. Mr. Riccio is a member of the Massachusetts Academy of Trial Attorneys, where he is a Regional Governor and Chairman of the Medical Negligence Committee. He is also a member of the Massachusetts Bar Association, where he is a former Co-Chair of the Health Law Council; the National Crime Victim Bar Association; the AAJ; and the Million Dollar Advocates Forum. He has been named a *Boston Magazine* Super Lawyer since 2005. He is on the Board of Directors of Massachusetts Citizens for Children.

Mr. Riccio became Board Certified as a Civil Trial Specialist by the National Board of Trial Advocacy in October 2000, and was recertified in October 2005. He is a Fellow in the American College of Legal Medicine. He is also a certified mediator.

Mr. Riccio has lectured extensively in Massachusetts and throughout the country on many medical, legal and trial practice topics and was a co-host on the WCRN Worcester radio program, *Talking About the Law.*
**The Honorable Karen Sage** was elected as judge of the 299th District Court in 2010. As Judge of the 299th District Court, she presides over felony, criminal matters. In addition to her criminal docket, Judge Sage has focused much of her efforts on creating new ways of dealing with defendants who suffer from substance abuse. Formerly, she served as an Assistant District Attorney for Travis County where she was given the task of creating the first felony mental health docket for the County. Before moving to Austin, Judge Sage worked as a prosecutor in the United States Attorney’s Office in the Eastern District of New York. Prior to working in the US Attorney’s Office, Judge Sage served as Counsel to the Mayor of Los Angeles.

Judge Sage is also an Adjunct Professor of Law at the Law School of the University of Texas where she teaches a class on the Ethics of Criminal Law.

Judge Sage’s began her legal career with the law firm of O’Melveny & Myers in Los Angeles, which she joined after graduating cum laude from the University of Minnesota.

**Bruce Seidberg, DDS, MScD, JD, FCLM**, currently serves as chief of dentistry at Crouse Hospital and senior attending in dentistry at St. Joseph’s Hospital in Syracuse, N.Y., in addition to maintaining a private practice in Liverpool. He is also a dental-legal consultant who has contributed articles to dental literature and chapters in numerous books, including Risk Management in Legal Medicine, Ethics, Morals, Law and Endodontics in Ingle’s Endodontics and the textbook Dentistry for the Special Patient. He has lectured at national and international meetings about the fields of dentistry and law.

Throughout his career, Dr. Seidberg has been active with the various dental organizations. He served two terms on the AAE Board of Directors and is a past president of the American College of Legal Medicine, Cayuga County Dental Society and New York State Association of Endodontists. He was also an officer of the AAE Foundation, American Dental Association Council on Communications and Pierre Fauchard Academy, and a Fellow of ACLM, the American College Dentists and American Association of Hospital Dentists. He is the secretary of the American Board of Medical Malpractice and the Onondaga County Dental Society in New York.

Dr. Seidberg is a Diplomate of the American Board of Endodontics and American Board of Medical Malpractice. In 2001, he received the AAE President’s Award, and from 1992-1994, he was the recipient of the President’s Award for Service from ACLM.

**Kenneth I. Shine, MD, MACP.** A cardiologist and physiologist, Dr. Shine graduated from the Harvard Medical School in 1961. He trained at Harvard’s acclaimed teaching hospital, Massachusetts General, where he became Chief Resident in Medicine in 1968.

In 1969 he joined the faculty at the University of California in Los Angeles, ultimately becoming Dean of the School of Medicine and Provost for Health Sciences in 1986. His leadership helped establish UCLA as one of the most respected medical schools in the country. He promoted major innovations in ambulatory education, community service for medical students and faculty, math and science education in the public schools, and major initiatives in biomedical sciences and health services research. He made changes in the School’s search processes in order to recruit women to the faculty and created active programs to stop sexual harassment among students and faculty. Dr. Shine created the Health Health care team, an interprofessional, interdisciplinary approach to cardiac care. In 1972 he supported early efforts to engage an “advanced practice nurse” in cardiac care.

In 1992 Dr. Shine was named President of the Institute of Medicine of the National Academy of Sciences, (now the National Academy of Medicine), a non-profit, non-partisan organization chartered to advise the federal government on health science and healthcare. According to his successor as President, Dr. Harvey Fineberg, under Dr. Shine’s leadership the Institute took on such crucially important issues as food safety, tobacco use and end of life care and became one of the most important forces to improve health in the nation. Perhaps the most controversial issues Dr. Shine confronted as President of the Institute was the quality of care in America which led to landmark reports, To “Err is Human” in 1999, and Crossing the Quality Chasm-A new Health System for the 21st Century in 2001. These reports found that medical errors were causing tens of thousands of death and many thousands of complications for patients and became powerful impetuses for changes.

He came to Texas in 2003 as Executive Vice Chancellor for Health Affairs in the University of Texas System with responsibility for six health Campuses. He brought a focus on quality of care to the State spearheading a project called, CODE RED, the critical condition of Health in Texas a statewide call to action to improve access to care, streamline medical education and increase the number of nurses and physicians. He actively supported efforts to expand the role of nurses in care and the development of the DNP degree. His work also laid the ground work for two new Medical Schools, in Austin and South Texas.
Charles Silver, JD, MA, holds the McDonald Endowed Chair in Civil Procedure at the University of Texas School of Law, where he also teaches about health law and policy. His published works include a series of peer-reviewed empirical studies of medical malpractice litigation in Texas. Professor Silver is currently working on a book on the health care payment system, the working title of which is Health Care Games.

Jack Snyder, JD, PhD, MPH, MSSA, is a physician-attorney-executive with more than 25 years of clinical, research, and administrative experience in academic, governmental, and industrial sectors of biomedicine. Jack currently directs corporate pharmacovigilance activities and manages the Washington (Rockville, MD) office of Cato Research Ltd., a full-service global CRO. Dr. Snyder has a keen interest in all aspects of product development, and derives a special satisfaction from collaborating with others to move new drugs, biologics, devices, and other products into the marketplace. Jack is a graduate of the Honors Medical Program at Northwestern University (B.S., M.D.), the Georgetown University Law Center (J.D.), the Graduate Program in Forensic Science at George Washington University (M.F.S.), the Johns Hopkins University Bloomberg School of Public Health (M.P.H.), the Graduate Program in Pharmacology and Toxicology at the Medical College of Virginia (Ph.D.), and the Johns Hopkins University Carey School of Business (M.S.I.S., M.B.A., Graduate Certificates in Financial Management, Investments, and Competitive Intelligence). Jack served an internship in internal medicine at the Tulane University Medical Center; residencies in anatomic, clinical, and chemical pathology at the University of Miami Medical Center, the Johns Hopkins Hospital, and the Medical College of Virginia Hospitals; and an NIEHS-supported fellowship in clinical pharmacology and medical toxicology at the Medical College of Virginia.

Dr. Snyder is licensed to practice medicine and law, and is Board-Certified in Occupational Medicine, Medical Toxicology, Clinical Informatics, Anatomic Pathology, Clinical Pathology, Chemical Pathology, Toxicological Chemistry, Clinical Chemistry, General Toxicology, Quality Assurance & Utilization Review, Legal Medicine, Public Health, and Regulatory Affairs. Jack is a Certified Physician Investigator, and a Certified Physician Executive who also holds a Certificate of Qualification to direct clinical laboratories. Jack has directed clinical and research laboratories and projects; taught law, medicine, and forensic science at the Thomas Jefferson University and the George Washington University; authored more than 100 manuscripts in medical, legal, and scientific publications; and presented more than 100 papers at national and international meetings.

Finally, Dr. Snyder is a past president of the American College of Legal Medicine, past Secretary of the American Board of Legal Medicine, and has attained fellowship status in the American College of Medical Toxicology, the American Academy of Clinical Toxicology, the Association of Clinical Scientists, the American Society of Clinical Pathologists, the College of American Pathologists, the National Academy of Clinical Biochemistry, the American Board of Quality Assurance & Utilization Review, and the American College of Legal Medicine.

Toan Foeng (Bill) Tham, BA, DDS, JD, FCLM, is practicing as a dentist and licensed attorney. Dr. Tham has been practicing dentistry full time at his own private practice, and an educator for twenty-one years since graduating from the University of Missouri Kansas City in 1991 with doctor of dental surgery degree. He entered into full-time academia teaching at the University of Nevada Las Vegas (UNLV) School of Dental Medicine in 2012.

Dr. Tham is the Principal Investigator of double blind research oral rinse study to determine the effect on Periodontal Disease conducted at UNLV School of Dental Medicine. He is the course director of general clinic stream at the university, clinical sciences faculty, and a mentor for sixteen dental students. He is the founder and advisor of UNLV Asian American Dental Student Association.

He is part of the Editorial Board of the Journal of Dentistry, Oral Disorders, and Therapy. He has published many articles in peer-reviewed journals and is the co-author of Rule of Law Index.

Dr. Tham is also a practicing attorney in Immigration and Nationality Law, Family Law, and Dental Malpractice, since getting his law degree from California Concord University School of Law in 2005. He is the past vice chair of American Bar Association Health Law Section, and currently the vice president and executive board member of Asian American Advocacy Clinic—a non-profit organization whose mission is to increase access to legal, advocacy, education, and support services for low income and linguistically and/or culturally marginalized communities.

He is the founding board and chairman of Global Oral Legal Dental Helping Hands Foundation, a non-profit organization to provide oral, dental services, and legal education worldwide.

Dr. Tham has over 23 years of experience in managing private practice, mentoring, research, and education. He has served as vice-president and secretary in several state-wide professional organizations, such as American Bar Association (ABA) Health Law Section, ABA Young Lawyer Section, and Tzu Chi Foundation Medical Section; currently, he is the chair of Disaster Relief and Medical Aid Section of Tzu Chi Las Vegas Foundation, chair elect of Professional, Ethical, and Legal Issues in Dentistry, and secretary of Practice Management Section of American Dental Education Association.
Veling W. Tsai, MD, JD, FCLM, Caring ENT, is a clinical assistant professor in the Department of Head and Neck Surgery at the University of California at Los Angeles – David Geffen School of Medicine. Dr. Tsai is also an attending physician in the Department of Surgery, Division of Head and Neck Surgery at Olive View – UCLA Medical Center in Sylmar, California. Additionally, Dr. Tsai is in private practice, and Chair of Department of Surgery at Alhambra Hospital in Alhambra, California. He attended UCLA and received a Bachelor of Arts degree in Geography/Environmental Science, graduating with Latin honors. Dr. Tsai then received his dual law and medical degrees from Southern Illinois University - School of Medicine and School of Law. Dr. Tsai completed his Head and Neck Surgery residency training at UCLA. He is licensed to practice both law and medicine in the State of California. Dr. Tsai has served on the Ethics committee of the American Academy of Otolaryngology – Head and Neck surgery for the last 10 years. He is also currently a member of the Board of Governors for American College of Legal Medicine.

Dr. Tsai continues to be actively involved in scholarly research by serving on the editorial board for the Journal of Legal Medicine.

Keegan Warren-Clem, is an attorney and the founding legal champion of Austin Medical-Legal Partnership (AMLPP). Through AMLP she works collaboratively with healthcare providers to improve health outcomes through legal assistance for patients and legal education for both patients and providers. Keegan also challenges local pediatric residents to explore connections between health, poverty, and unmet legal needs as part of the community pediatrics rotation. She frequently speaks and writes on the Affordable Care Act, medical privacy, and public health law. Keegan’s current research is in empirical health law studies, focusing on data analytics and a novel adaptation of population health norms for attorney use. She is admitted to practice in Texas and is a member of the State Bar College, an honorary society of lawyers. Keegan earned her B.A. with honors from the University of Arkansas, her J.D. from The University of Texas, and her LL.M. in Health Law and Policy from Southern Illinois University.

Cyril H. Wecht, MD, JD, FCLM received his M.D. degree from the University of Pittsburgh and his J.D. Degree from the University of Maryland. He is certified by the American Board of Pathology, the American Board of Disaster Medicine, and the American Board of Legal Medicine.

Dr. Wecht is actively involved as a medical-legal and forensic science consultant, author, and lecturer, and was the elected Coroner of Allegheny County for 20 years. He has performed approximately 19,000 autopsies, and reviewed or been consulted on approximately 39,000 additional post-mortem examinations, including cases in several foreign countries.

Dr. Wecht holds several professorial faculty positions at the University of Pittsburgh, Duquesne and Carlow Universities. He is the author or co-author of 585 professional publications, and editor or co-editor of 46 books.

Dr. Wecht has appeared as a frequent guest on numerous national TV and radio shows, discussing famous cases, many of which are discussed in his books, Cause of Death, Grave Secrets, Who Killed JonBenet Ramsey, Mortal Evidence, Tales from the Morgue, A Question of Murder, and Final Exam.

Tim Weitz, JD, CAE, founding Partner, McDonald, Mackay, Porter & Weitz, LLP.

Katherine Weno, DDS, JD

William J. Winslade, PhD, JD, is the James Wade Rockwell Professor of Philosophy in Medicine, Professor of Preventive Medicine and Community Health and Professor of Psychiatry and Behavioral Sciences, and is a member of the Institute for the Medical Humanities at the University of Texas Medical Branch, Galveston, Texas and Adjunct Professor of Philosophy at the University of Texas, Austin. He is also Distinguished Visiting Professor of Law at the University of Houston Health Law and Policy Institute. His academic and professional background includes a Ph.D. in philosophy from Northwestern University, a J.D. from UCLA Law School, a Ph.D. in Psychoanalysis from the Southern California Psychoanalytic Institute, and an Honorary D. H. L. from Monmouth College. He is a Fellow of the Hastings Center and was a ZIF Fellow (2009-2011).

Philosophic, legal, and psychoanalytic ideas are applied in his work to the study of human values in science, medicine, technology and law. Professor Winslade's book, Confronting Traumatic Brain Injury: Devastation, Hope and Healing, was published by Yale University Press in 1998. He has co-authored with Albert Jonsen and Mark Siegler, Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine, 8th Edition (McGraw-Hill, 2015). His current research interests focus on neuroethics and brain studies, especially how consciousness and loss of consciousness are related to problems such as dementia, personhood and treatment decisions. A related recent publication is “Human Dignity, Human Consciousness, and Human Life,” in Menschenwürde und Moderne Philosophie, Legalphilosophie, und Psychosoziale Wissenschaften (Hans-Hermann Hahn, ed.)). Nomos Verlagsgesellschaft, Baden-Baden, 2011.

I believe that neuroethics is among the most important areas for interdisciplinary collaboration between neuroscientists and other scholars. However, I am concerned that hasty extrapolations and premature popularizations from limited data promotes oversimplification of complex issues. The interactions among brains, bodies, minds and environments calls for careful and comprehensive research and reflection.
Douglas Wolff, DDS, JD, FCLM, is a dentist with Park Dental, a licensed attorney, and a member of the Minnesota State Board of Dentistry. Doug's up-to-date presentations on dental/legal topics both educate and entertain all members of the dental team.

Hilary H. Young, JD, is a partner of Joy & Young, L.L.P., in Austin, Texas. She practices in the regulatory, licensing, and administrative areas of health law, and is board certified in Health Law by the Texas Board of Legal Specialization. Her practice includes advising institutional health care providers on compliance with various state and federal laws, including the Emergency Medical Treatment and Labor Act (EMTALA), and defending providers in government enforcement actions.

Ms. Young speaks regularly on health law topics. She is an officer of the American Bar Association Health Law Section, and is Past Chair of the State Bar of Texas Health Law Section Council. Ms. Young earned her J.D. from the University of Texas School of Law, an M.A. from the University of Oklahoma, and an A.B., Cum laude, from Duke University. Before entering private practice, Ms. Young served as a law clerk for the late Jerre S. Williams, Senior Judge for the United States Court of Appeals for the Fifth Circuit. Ms. Young attended the University of Texas at Austin and received a B.A. in 1991 with special honors in the Plan II Honors Program. Ms. Young is admitted to the bars of the State of Texas and the United States Court of Appeals for the Fifth Circuit.

Pamela Zarkowski, JD, FCLM

Karin M. Zaner, JD, FCLM, practices in the Litigation Section at Kane Russell Coleman & Logan in Dallas, where she is a director.

Her experience includes litigation of general business and commercial disputes before both state and federal trial courts, but she now focuses mainly on health care law. Ms. Zaner represents various clients (mainly physicians and physician groups) in a variety of health care matters, including those relating to HIPAA, peer review, credentialing, physician employment and non-competes, practice disputes, as well as Texas Medical Board issues.

Ms. Zaner attended the University of Texas at Austin and received a B.A. in 1991 with special honors in the Plan II Honors Program. She attended the University of Texas School of Law and received her J.D. in 1994.

Karin Waugh Zucker, MA, JD, LLM, FCLM, Prof., is a Professor of Healthcare Administration, Baylor University, and a Consultant in Bioethics to Brooke Army Medical Center. She teaches medical ethics (Clinical Ethics, Organizational Ethics, Law and Ethics of War and Terrorism, and Ethics in Film) and healthcare law (Healthcare Jurisprudence and Healthcare Contracting and Negotiations. She is a retired, Army JAG, lieutenant colonel. Among her assignments were tours as the Command Judge Advocate for the U.S. Army Medical Command Europe and as the Legal Counsel for the Armed Forces Institute of Pathology and the Collaborative Center for the Investigation of AIDS. While in the Army, she also held academic appointments at the University of Maryland, the University of Texas Health Science Center - Houston, Texas Wesleyan University, and Tulane University. She is now a Department of the Army civilian employee with the Army - Baylor University Graduate Program in Health and Business Administration at the Army Medical Department Center and School in San Antonio, Texas. Professor Zucker has lectured widely on legal medicine and bioethics and, since 2007, has been a member of the faculty of the European Summer University on Medical Ethics and Law in Toulouse, France.
WELCOME & ANNOUNCEMENTS

FRIDAY, FEBRUARY 26, 7:45 AM - 8:00 AM

Grand Ballroom A

Alejandro Moreno, MBBS, MPH, JD, FACP, FCLM,, Annual Meeting Co-Chair
Daniel L. Orr II, DDS, PhD, JD, MD, FCLM, Annual Meeting Co-Chair
Bruce Seidberg, DDS, MScD, JD, FCLM, Annual Meeting Dental Session Chair
JOINT GENERAL SESSION I
RECENT DEVELOPMENTS IN LEGAL MEDICINE

FRIDAY, FEBRUARY 26, 8:00 AM - 9:50 AM

Grand Ballroom A

MODERATOR:
Theodore R. LeBlang, JD, FCLM
Federal and State Legislative Update 2015

Veling Tsai, MD, JD, FCLM
Austin, TX
Feb. 26, 2016

Health Insurance Exchanges – 2016

- State-based (13 states and DC);
- Federally-supported State-based (4 states);
- Partnership (7 states);
- Federally-facilitated (27 states).

Health Insurance Exchange

State Health Insurance Marketplace Types, 2016

Definitions

- State-based Marketplace: States running a State-based Marketplace are responsible for performing all Marketplace functions. Consumers in these states apply for and enroll in coverage through healthcare.gov.
- Federally-supported State-based Marketplace: States with this type of Marketplace are responsible for performing all Marketplace functions. Consumers in these states apply for and enroll in coverage through healthcare.gov.
- Partnership Marketplace: States entering into a Partnership Marketplace may perform some Marketplace functions and will still perform the remaining Marketplace function. Consumers in states with a Partnership Marketplace apply for and enroll in coverage through healthcare.gov.
- Federally-facilitated Marketplace: States entering into a Federally-facilitated Marketplace may perform some Marketplace functions and will still perform the remaining Marketplace function. Consumers in states with a Federally-facilitated Marketplace apply for and enroll in coverage through healthcare.gov.

2014 Federal Legislation - Enacted

- H.R. 1624: Protecting Affordable Coverage for Employees Act
- H.R. 876: NOTICE Act
- S. 984: Steve Gleason Act of 2015
- S. 1362: A bill to amend title XI of the Social Security Act to clarify waiver authority regarding programs of all-inclusive care for the elderly (PACE programs).
- S. 599: Improving Access to Emergency Psychiatric Care Act
- S. 2425: Patient Access and Medicare Protection Act
- S. 971: Medicare Independence at Home Medical Practice Demonstration Improvement Act of 2015
- S. 139: Ensuring Access to Clinical Trials Act of 2015
- S. 1461: A bill to provide for the extension of the enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals through 2015.
- S. 799: Protecting Our Infants Act of 2015
- S. 1907: Medicare for All Act of 2015
- S. 2108: Health Care Transparency and Accountability Act of 2015
- S. 2130: bipartisan legislation to expand current department of health and human services programs
- S. 2131: bipartisan legislation to reauthorize the health centers capitation rate adjustment
- S. 2132: bipartisan legislation to improve access to human services
- S. 2133: bipartisan legislation to expand/establish low-income

State Legislation Update

- Using National Conference of State Legislature database.
- Using the topics: Access to Primary Care, Authorize/Plan/Fund, Challenging and Alternatives, Essential Health Benefits, Health Centers, Health Information Technology, Health Insurance Exchanges, Health Insurance Reform, Medicaid and CHIP, Other, Prevention and Wellness, Workforce and Providers.
- 385 bills enacted in 50 states and DC in 2015
General Categories of State Legislations

- Compliance with Affordable Care Act (ACA)
- Appropriations
- Expansion of Medicaid
- Increase coverage to autism spectrum disorders and pediatric dental care.

Enacted Healthcare Legislation – State by State Breakdown

- AL - 5
- AK - 5
- AR - 0
- AZ - 0
- CA - 23
- CO - 6
- CT - 30
- DE - 3
- DC - 3
- FL - 5
- GA - 4
- ID - 0
- IL - 0
- IN - 0
- IA - 1
- KS - 0
- KY - 0
- LA - 15
- ME - 1
- MD - 3
- MA - 0
- MI - 0
- MN - 1
- MS - 0
- MO - 0
- MT - 1
- NE - 1
- NH - 1
- NJ - 1
- NM - 0
- NY - 4
- NC - 1
- ND - 0
- OH - 0
- OK - 8
- OR - 10
- PA - 1
- RI - 5
- SC - 1
- SD - 2
- TN - 4
- TX - 32
- UT - 29
- VT - 3
- VA - 18
- WA - 11
- WV - 0
- WI - 1
- WY - 0

Alabama

- Delay Implementing ACA - Act No. 2015-279
  Urges the United States Congress to take necessary measures to delay the mandated implementation of EIC-50 and lessen the burden on state medical practices.

Arizona

- Health Care Cost Containment System - Act No. 91
  Helps Arizona health care providers reduce costs by limiting the number of times a hospital emergency department may treat a patient for a specified period and in the process mandates emergency services, requires certain reports.
- Drastic Payments To Health Care Providers - Act No. 265
  Applies to direct payments to health care providers, requires a receipt, limits that if an enrollee pays a health care provider or health care facility that is an out-of-network provider the direct pay price for a service covered under the enrollee’s health care plan, the amount paid by the enrollee shall be adjusted to the enrollee’s network deductible with any remaining amount being applied to the enrollee’s out-of-network outlay. Excludes certain government plans.

Arkansas

  Requires the state to provide a list of procedures for treatment of a healthy person under the health care plan, limits the number of times a hospital emergency department may treat a patient for a specified period and in the process mandates emergency services, requires certain reports.
- Health Insurance Premiums - Act No. 32
  Provides the assessment of special care of a healthy person, which includes the definition of a healthy person and the reasonable cost of the assessment. Requires that the state provide a list of procedures for treatment of a healthy person under the health care plan, limits the number of times a hospital emergency department may treat a patient for a specified period and in the process mandates emergency services, requires certain reports.
- Health Care Plan - Act No. 1133
  Requires a health care plan to contact and inform the enrollee of the designated network of health care providers, requires the state to provide a list of procedures for treatment of a healthy person under the health care plan, limits the number of times a hospital emergency department may treat a patient for a specified period and in the process mandates emergency services, requires certain reports.

California

- Health Care Coverage; Immigration Status - Act No. 709
  Relates to individuals under a specified age enrolled in restricted-scope Medi-Cal to be enrolled in the full-scope benefits. Requires monthly updates to specified legislative committees, requires such individuals to enroll in a Medi-Cal managed care health plan.

ACL M 56th Annual Meeting Program Book
California
- Reproductive FACT Act - Act No. 700
  Enacts the Reproductive FACT Act, requires a licensed covered facility to disseminate a notice to all clients stating the State has public programs that provide immediate free or low-cost access to family planning services, prenatal care, and abortion, for eligible women, requires an unlicensed covered facility to disseminate a notice that the facility is licensed as a medical facility by the State, authorizes a civil penalty against facilities that do not comply.

Colorado
- Health Insurance Parity for Autism Spectrum Disorders - Act No. 106
  Mandate / EHDI: Specifies autism spectrum disorders are not to be treated as a mental illness for purposes of health care coverage, clarifies health benefit plans must include benefits for autism that are not less restrictive than benefits available for a physical illness, clarifies that nationally registered behavior technicians may provide services to a person under the supervision of another autism services provider.

Connecticut
- Comprehensiveness: Children's Behavioral Health Act - Act No. 15-27
  Considers implementation of a comprehensive children's mental, emotional, and behavioral health plan implementation advisory board to advise on the implementation of the comprehensive health plan implementation plan for children with behavioral health services

Delaware
- Newborn Screening Program Act No. 88
  Creates the Newborn Screening Program, specifies screening for metabolic disorders and other conditions, establishes a newborn screening advisory committee, establishes a newborn screening advisory committee, provides for the operating of the Newborn Screening Program and the newborn screening advisory committee.

Georgia
- Reimbursement for Skin Substitutes Used for Burns - Act No. 207
  Requires the insurance company to provide reimbursement for the treatment of burns using skin substitutes or other approved coverings for prescribed treatment based upon the burn's diagnosis and a medical condition, provides for certain insurance coverage of burn except burns that are not covered by any other policy.

Illinois
- Insurance Code Act No. 407
  Amends the Insurance Code and the Health Maintenance Organization Act, states that insurance companies shall provide coverage for breast reconstruction, provides that carriers for breast reconstruction for women who have breast cancer, provides that carriers shall provide coverage for breast reconstruction for women who have had a mastectomy.

- Physician Right to Know Act - Act No. 350
  Amends the Physician Right to Know Act, provides that a hospital which has been given notice that any code on its hospital's messages, provides that a hospital or its physician agrees to a hospital or its physician's request to provide the information, requires hospitals to provide information to other hospitals or other entities specified in the act.
Kentucky

Cancer Screening - Act No. 16
Relates to removing barriers to colorectal cancer screening, requires that health benefit plans provide complete coverage of colorectal cancer screening, provides that coverage shall not be subject to a deductible or coinsurance for or services received from participating providers under the health benefit plan.

Louisiana

Acute Care - Act No. 229
Authorizes the issuance of a certificate of authorization for acute care services. The certificate shall be issued by the Acute Care Services Board. The certificate shall be valid for the period specified on the certificate, not to exceed one year.

Maryland

Insurance Coverage for Ostomies - Act No. 23
Mandates that health benefit plans cover ostomy-related services, including supplies used for the treatment of ostomies, prosthesis, and ostomy-related medical supplies.
Mississippi

- Anti Cancer Medications - Act No. 490
  Prohibits health plans that cover injected, intravenously administered and oral anticancer medications from requiring a higher co-payment, deductible or coinsurance amount for patient administered medications than they require for medications injected or intravenously administered, affects the state and school employees health insurance management board to accept bids for surgical services that include a rate bundle and payment for orthopedic, spine, burn, cardiac, cardiovascular and general surgeries.

Missouri

- Eating Disorder Insurance Coverage
  Requires health benefit plans to provide coverage for the diagnosis and treatment of eating disorders, limits the coverage to medically necessary treatment that is provided by a licensed treating physician, psychiatrist, psychologist, professional counselor, clinical social worker, or licensed marital and family therapist.

Nevada

- Interstate Compact on Mental Health - Act No. 223
  Requires and enacts the Interstate Compact on Mental Health, provides for transfers of patients to another state if care and treatment would be improved, requires a state that transfers a patient to another state to pay costs of transporting the patient unless the states arrange for a different allocation of such costs, requires a guardian, authors agreements for the return of certain indigent residents discharged as having recovered from mental illness to their county of residence within the state.

New Hampshire

- Definition of Telemedicine - Act No. 2015-246
  Clarifies when it is appropriate to use telemedicine in provider-patient medical circumstances, provides that a practitioner shall not prescribe certain controlled drugs by means of telemedicine except when treating patients in community mental health programs, relates to a physician providing telemedicine services directly to a patient, relates to medical records, relates to Medicaid coverage for telehealth services, relates to advanced practice registered nurse-patient relationships.

New Mexico

- Informed Consent for Genetic Testing - Act No. 156
  Relates to health care, except a clinical laboratory performing services pursuant to a written order from a health care practitioner from the requirement to obtain informed consent for genetic analysis or testing.

North Dakota

- Telehealth Insurance Coverage - Act No. 425
  Relates to the Public Employees Retirement System uniform group insurance coverage of telehealth, provides the board shall provide for certain health benefits coverage under a policy that provides coverage for health services delivered by means of telehealth which is the same as the coverage for health services delivered by in-person means, provides expenses paid for covered health services delivered by telehealth may be negotiated in the same manner as covered health services which are delivered in person.
North Dakota
*Cancer Treatment Insurance Coverage - Act No. 218*
Relates to insurance coverage of cancer treatment medications, requires that copayment, deductible, and coinsurance amounts for patient-administered cancer treatment medications do not exceed the amounts for cancer treatment medications that are injected or intravenously administered by a health care provider, regardless of the formulation or benefit category, prohibits an insurer from increasing copayments or deductibles or reclassifying benefits in order to avoid compliance.

Oklahoma
*Insurance - Act No. 74*
Relates to insurance, provides that a health benefit plan that provides coverage for cancer therapy shall be prohibited from holding proton radiation therapy to a higher standard of clinical evidence for medical policy benefit coverage determinations than the health plan requires for coverage of any other radiation therapy treatment, provides that nothing in these provisions shall be construed to mandate the coverage of proton radiation therapy by a health benefit plan.

Rhode Island
*Insurance Coverage for Mental Illness - Act No. 2015-209*
Requires payors providing insurance coverage for the treatment of mental health and substance abuse disorders to rely upon criteria of the American Society of Addiction Medicine when developing coverage for levels of care for substance use disorder treatment. (Relates to essential health benefits)

South Dakota
*Cancer Treatment Medication Insurance Coverage - Act No. 282*
Relates to cancer treatment medication insurance coverage, provides that a health benefit plan that covers injected or intravenously administered cancer treatment medications shall provide no less favorable benefits for prescribed, orally administered anticancer medications, regardless of formulation or benefit category, prohibits an insurer to reclassify benefits for cancer treatment medications or to increase a copayment, deductible, or coinsurance amount unless the increase is applied to all benefits.

Tennessee
*Health and Ambulance Insurance Copayments - Act No. 187*
Prohibits health insurance entities from charging a covered person a greater copayment or coinsurance amount for primary care services rendered during an office visit to a physician assistant than those charged for primary care services rendered during an office visit to a physician.

*Physician Referral for Health Care Services - Act No. 518*
Provides that a managed health insurance entity shall not contract or employ an agent to contact a patient of a contracted physician to change a referring provider unless certain actions are followed, requires the patient to be provided orally and electronically of the right to discuss a change of referral with the existing provider before any appointment is changed, authorizes notification of the patient that the provider selected is not in the network and there may be costs.

Texas
*Managed Care Plans - Act No. 2715*
Relates to the operation of certain managed care plans with respect to certain physicians and health care providers, provides that a health maintenance organization may not terminate or restrict participation of a physician or provider solely for informing an enrollee of the full range of available physicians and providers, including out-of-network providers, excludes child health plans, the health benefits plan for children, Medicaid programs and the Medicaid managed care program.
Utah

- **Antimicrobial Medications Act No. 23**
  - Modifies the State Antimicrobial Act to address breastfeeding or medication conditions related to breastfeeding, includes breastfeeding or medication conditions related to medication under pregnancy, childbirth, or pregnancy-related conditions.

- **Electronic Cigarettes Act No. 132**
  - Relates to electronic cigarette products, requires a license in order to sell or distribute an electronic cigarette product, provisions criminal penalties for violations, provides product quality and labeling standards for an electronic cigarette product, gives the Department of Health the authority to determine the product quality, require content, packaging, and labeling standards, and the advertising and electronic cigarette product as a tobacco cessation device, prohibits minors in tobacco specialty shops.

Vermont

- **All Payer Model for Health Care Act No. 54**
  - Relates to an all-payer model for health care, to be achieved through a waiver from the Centers for Medicare and Medicaid Services, includes hospitals, provides a maximum allowable cost for pharmacy benefit managers relating to reimbursement rates, provides an administrative appeals process to allow a dispensing pharmacy provider to contest a limited maximum allowable cost, requires notice of hospital observation status, including patients with commercial insurance, amends the tobacco products excise tax.

Washington

- **Palliative Care Insurance Coverage Act No. 22**
  - Provides for group or blanket insurance coverage of home health benefits for persons seeking palliative care in conjunction with treatment or management of serious or life-threatening illness, provides that such persons need not be homebound to be eligible for coverage, relates to coverage for employees.

West Virginia

- **Medical Professional Liability Act No. 168**
  - Relates to medical professional liability; controlled increases in cost of liability insurance and maintained access to affordable health care services, increases the limitation on civil damages in medical malpractice cases, limits admissibility of certain evidence, requires adjustment of verdicts for past medical expenses, including a write-off; includes pharmacies and emergency medical services caps, relates to admission of certain government, health care provider or health care facility information.

Thank you for your attention and enjoy the rest of the meeting!
Federal Cases

- The Affordable Care Act (ACA)
  - State and Federal exchanges
  - Religious exemptions from the contraception mandate
- Lethal injections
- Pregnancy Discrimination and the ADA
- Abortion
- Free speech and firearms
- Vaccines

The ACA – State and Federal Exchanges

  - The ACA requires a health care insurance marketplace ("exchange") in every state.
  - The ACA allows tax credits for any "applicable taxpayer" but only specifies that tax credits may go to taxpayers who enroll in "an Exchange established by the State."
  - Central question: are tax credits available to consumers in an Exchange established by the federal government?

The ACA - Contraception Mandate and Religious Exemptions

- Sharpe Holdings, Inc. v. U.S. Dept. of Health and Human Services (8th Cir. 2015) 801 F.3d 927.
  - Nonprofit religious organizations offering self-insurance plans challenged the contraception mandate in the ACA and the accommodation process for religious employers, claiming that the mandate and accommodation process violated the Religious Freedom Restoration Act (RFRA) and the Free Exercise Clause of the First Amendment.
  - The U.S. District Court for the Eastern District of Missouri enjoined enforcement of the mandate.
  - Holding:
    - The accommodation process by which these organizations could gain exemption from the ACA violated the RFRA because it substantially burdened the free exercise of their religious beliefs.
    - The accommodation process was not the least restrictive means to further the federal government’s interest in ensuring equal access to all contraceptives.

Deadly Medicine

  - State death-row inmates brought an action under 42 U.S.C.§ 1983 alleging that Oklahoma's three-drug lethal injection protocol violated the Eighth Amendment because it created an unacceptable risk of severe pain.
  - United States District Court for the Western District of Oklahoma denied inmates' motion for a preliminary injunction.
  - "Holding that the Eighth Amendment demands the elimination of essentially all risk of pain would effectively outlaw the death penalty altogether." (Id. at p. 233.)
  - Holdings:
    - The death row inmates failed to prove that any risk of harm was substantial compared to a known and available method of execution.
    - The district court did not commit clear error in finding that midazolam (a sedative) is highly likely to render a person unable to feel pain when he is executed.
Pregnancy Discrimination and the Americas with Disabilities Act

- **Young v. United Parcel Service (2015) 135 S.Ct. 1338.**
  - UPS employee brought an action against her employer under the Americans with Disabilities Act (ADA) and the Pregnancy Discrimination Act (PDA) for failing to accommodate her lifting restriction while pregnant.
  - UPS had a light-duty-for-injury policy for other disabled persons but not for pregnant workers. UPS sought summary judgment.
  - **Holding:**
    - An employee alleging disparate treatment in violation of the PDA may apply the McDonnell Douglas framework.
    - If an employer accommodates a large percentage of non-pregnant employees and fails to accommodate a large percentage of pregnant employees, this can create a genuine issue of material fact as to whether an employer’s policies impose a significant burden on pregnant employees.

Free Speech and Firearms

- **Wollschlaeger v. Governor of the State of Florida (11th Cir., Dec. 14, 2015, 12-14009) 2015 WL 8639875**
  - The State of Florida Firearm Owners’ Privacy Act.
    - Restricts “irrelevant inquiry and record-keeping” by physicians about patients’ use and possession of firearms.
    - Instructs health care providers to refrain from inquiring about whether the patient and her family own firearms unless the provider believes in good faith that the information is relevant to the patient’s medical care, safety, or the safety of others.
    - States that health care providers may not “intentionally enter” information about a patient’s ownership of firearms into the patient’s medical record that the practitioner knows is not “relevant” to the patient’s medical care, safety, or the safety of others.
    - Violation of any of the Act’s provisions constitutes grounds for disciplinary action including fines, restriction of practice, return of fees, probation, and suspension or revocation of her medical license.
  - Physicians and physician interest groups filed for an injunction and argued that the law facially violated the First and Fourteenth Amendments of the U.S. Constitution.
  - **Holding:**
    - The state’s interest in protecting the Second Amendment rights of patients is compelling and the law is narrowly tailored enough to advance that interest. Therefore, the law survives strict scrutiny.

State Cases

- **Topics include:**
  - Abortion
  - Experts in medical malpractice cases
  - Rescission of malpractice insurance
  - Administrative remedies
  - Breach of contract
  - Licensing and the separation of powers

Abortion

- **Whole Woman’s Health v. Cole (5th Cir. 2015) 790 F.3d 563 modified. (5th Cir. 2015) 790 F.3d 598 and cert. granted, (2015) 136 S.Ct. 499.**
  - On behalf of themselves and their patients, abortion providers sued State of Texas officials seeking declaratory and injunctive relief against the enforcement of amendments to state laws regulating abortion. Disputed provisions included:
    - A physician performing an abortion needed to have admitting privileges at a hospital within thirty minutes of the abortion location.
    - All abortion clinics had to comply with standards which apply to ambulatory surgery centers.
  - **Holding:**
    - The requirement for a physician to have admitting privileges was not facially unconstitutional.
    - Providers’ claim that the requirement for a physician to have admitting privileges is facially unconstitutional is barred by res judicata.
    - Provider did not establish that the ambulatory surgery center standards were facially unconstitutional.
    - Res judicata did not bar plaintiff’s as-applied claim.
  - The disputed statutes did not place a substantial obstacle in the path of a woman seeking an abortion at a clinic in El Paso, although the statutes did provide a substantial obstacle for a woman seeking an abortion at a clinic in Austin.

Vaccinations

  - Parents of minor unvaccinated children challenged the constitutionality of New York’s statutory vaccination requirement and a state regulation allowing unvaccinated children to be excluded from public school based on outbreak of preventable disease.
  - The Court of Appeals held that:
    - The statute does not violate substantive due process or violate the Free Exercise Clause.
    - The children’s parents failed to state an equal protection claim.
  - SCOTUS denied a petition for certiorari.

Abortion

- **Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Medicine (Iowa 2015) 865 N.W.2d 252**
  - The Iowa Board of Medicine established standards of practice that prohibit abortions via telemedicine in Iowa. Plaintiffs filed suit claiming that the rule was both improperly enacted and that it violated the Iowa Constitution.
  - The Board conceded that a woman’s right to an abortion under the Iowa Constitution is coextensive with the federal right. Using the federal undue burden test, the Supreme Court of Iowa concluded that the disputed rules placed an undue burden on a woman’s right to terminate her pregnancy as defined by federal constitutional precedents.
Expert Witnesses

  - A patient filed suit against a hospital and an endocrinologist, asserting claims of malpractice and lack of informed consent.
  - The patient plaintiff’s expert witness failed to lay the foundation for familiarity with endocrinology.
    - He specialized in pathology.
    - He did not indicate whether he had experience or training in endocrinology.
    - He evinced no particularized knowledge of testosterone replacement therapy.
    - He demonstrated no familiarity with relevant literature.
    - Nor did he otherwise show that he was familiar with the applicable standards of care.
  - The Supreme Court, Appellate Division, held that the expert’s affidavit was of no probative value and determined that the lower court properly dismissed the cause of action alleging medical malpractice.

Administrative Remedies

  - The Department refused to pay claims that Providers submitted. Providers requested and received an administrative review.
    - The administrative law judge (ALJ) ruled in favor of Provider in part and in favor of the Department in part.
    - Before the ruling could become final, the ALJ rejected the first ALJ's decision and remanded it for reconsideration.
  - Provider filed a petition for a writ of administrative mandamus in the superior court, seeking an order to direct the Department to withdraw the Chief ALJ’s decision and remanded it for consideration to a different ALJ.
  - The administrative law judge (ALJ) voted in favor of Provider in part and in favor of the Department in part.
  - Before the ruling could become final, the Chief ALJ rejected the first ALJ's decision and remanded it for reconsideration to a different ALJ.
  - Provider filed a demurrer, arguing that Provider failed to exhaust administrative remedies because a final decision had not been ordered. The trial court sustained the demurrer without leave to amend.
  - Holdings:
    - The doctrine of administrative remedies bars the Provider’s petition.
    - The “futility exception” to the exhaustion of remedies requirement did not apply.
    - The inadequate remedy exception does not apply.

Rescission of Malpractice Insurance

  - Central question: whether the Rhode Island Medical Malpractice Joint Underwriting Association (RIJUA) must defend and indemnify a podiatrist (Dr. Stoddard) in a medical malpractice action pending in New Jersey.
  - The policy was rescinded after the podiatrist made material misrepresentations concerning the state in which he maintained his primary practice.
  - The claims arose before the rescission of his policy
  - The New Jersey Supreme Court held that Dr. Stoddard’s misrepresentations “went to his eligibility of insurance through the RIJUA.” Because of the rescission, he was without coverage to respond to the patient’s claim of malpractice. Claims that arise prior to discovery of the misrepresentation are excluded from coverage.

Breach of Contract

  - Plaintiff, an insured, denied claims from Defendant, a medical provider, after Defendant refused to answer material questions under oath that Plaintiff asked as part of an investigation.
  - Defendant was awarded some claims through arbitration.
  - Plaintiff sought declaratory judgment that Defendant was not entitled to no-fault benefits. Defendant counter-claimed for attorney fees and compensation.
  - Plaintiff moved for summary judgment on the grounds that Defendant engaged in upcoding and billed for unnecessary or non-existent treatments. Plaintiff also argued that Defendant’s refusal to answer material questions was a breach of the condition precedent in the insurance policies requiring cooperation when examined under oath.
  - Holding: Defendant’s “failure to answer all relevant questions” constitutes a material breach of contract that precludes his recovery.

Licensing and the Separation of Powers

  - One Nevada state law grants physicians the right to judicial review of the board’s final decisions. Another state law prohibits district courts from entering a stay of the board’s decision pending judicial review. As a matter of first impression, the Supreme Court of Nevada determined that the prohibition against stays violated the state’s constitutional separation of powers doctrine.
  - “By simultaneously extinguishing the court’s ability to impose a stay where the progression of sanctions would impair or eliminate the purpose of seeking judicial review, the statute impermissibly acts as a legislative encroachment on the court’s power to do what is reasonably necessary to administer justice.” (Id. at p. 511.)
GENERAL SESSION II
DISCIPLINARY ISSUES OF HEALTH PROFESSIONALS

FRIDAY, FEBRUARY 26, 10:00 AM - 11:00 AM

Grand Ballroom A

MODERATOR:
David Donnersberger, MD, JD, FCLM
Disciplinary Issues of Physicians with Behavioral and Mental Health Problems

February 7, 2016

Katherine A. Hawkins, MD, JD, FCLM
Executive Secretary, Board for Professional Medical Conduct
New York State Department of Health

February 7, 2016

Behavioral Problems in Physicians

• The “disruptive physician”
  – The verbally abusive physician
  – The condescending physician
  – The unreachable physician
  – The rounding at odd hours physician
• Impact on patient care
• Facility or practice options
• Counseling and monitoring
• Assessment for mental illness or substance abuse
• Reporting obligations

February 7, 2016

Mental Health Problems in Physicians

• Depression
• Anxiety
• Bipolar disorder
• Schizophrenia
• Personality disorder
• Cognitive decline and dementia

February 7, 2016

Mental Health Problems in Physicians

• Physician reluctance to accept problem
• Physician reluctance to seek help
• Perceived lack of time, fear of stigma, impact on career
• Physician tendency to self-medicate
• Failure to diagnose and treat
• Risk of patient harm
• Risk of physician suicide

February 7, 2016

Substance abuse in physicians

• Statistics
• Statistics by specialty
• Drugs of choice
  – Alcohol
  – Prescription drugs
  – Illicit drugs
• Risk of relapse
• Patient harm
• Death due to accidents
• Death due to overdose
Reporting obligations

- On the part of health care facilities
- On the part of group practices
- On the part of other licensed professionals
  - No requirement the physician/patient privilege be violated if information was learned solely as a result of rendering treatment to another physician
- Reasonable suspicion
- Reporting vs referral to Physician Health Program
- On the part of law enforcement

Due process

- Investigation of complaints
- Interview opportunity
- Legal representation
- Impairment evaluation
- Consent agreements
- Formal Board hearings
- Board disciplinary and non-disciplinary actions
- Public and non-public Board actions

Legal definitions

- Misconduct
  - Practicing the profession while impaired by alcohol, drugs, physical or mental disability
  - Being a habitual user of alcohol, or being dependent on or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having similar effects . . . or having a psychiatric condition which impairs the licensee’s ability to practice

Legal issues - investigation

- Consent, Board order, or Court order required for access to medical records of investigated licensee
- Federal confidentiality of Alcohol and Drug Abuse patient records
- Physician Health Program records
- Waiver by licensee

Legal Process

- Medical Board has authority to order a medical or psychiatric evaluation
- Medical Board has authority to issue an order authorizing the release of medical records or other protected health information pertaining to licensee’s psychiatric or mental condition
- Where the Board has reason to believe the licensee may be impaired
- Upon notice to licensee and opportunity to be heard

Protection of the public

- Summary suspension of license
- Temporary surrender
- Indefinite suspension
- Confidential orders with monitoring
- Formal disciplinary hearing
- Probation with monitoring
- Conditional restoration
- Permanent surrender
- License revocation
Restoration/Modification of Board Orders

- Temporary surrenders and indefinite suspensions
- Multiple documents are submitted
- Witness testimony
- Burden of proof is on Licensee
- Board must be satisfied the Licensee is no longer incapacitated for the practice of medicine and is competent in his/her field of practice
- Conditions are always applied

Recovery Monitoring

- Goals
  - Remain drug and alcohol free
  - Return to practice
  - Patient protection
- Physician Health Programs
- Sobriety monitor
- Practice supervisor
- Therapist(s)
- Random, unannounced specimen collections
- Forensic drug testing
- Scheduled reporting to Board

Likelihood of Recovery and Re-entry into Practice

- Physician diagnosis
- Duration of illness
- Physician specialty
- Modification in practice
- Support system
My comments are general answers to frequently asked questions. Specific circumstances and personal considerations may vary and lead to different conclusions. This information cannot address all laws and regulations that may apply nor their actual application in particular instances. Since laws and regulations are constantly changing and individual circumstances may warrant individualized advice and representation, this information does not constitute legal advice and should not be relied upon as a substitute for a personalized legal consultation with a licensed Texas attorney. This information is for general educational purposes only and should not be considered individual legal advice. This material is not intended to take the place of legal or professional advice or services and a reader or listener should obtain independent legal advice before undertaking any activity that may be within the scope of any law or regulation discussed in these materials. The review of this information and participation in this course does not create an attorney-client relationship. Paying attention may cause nausea, vomiting, or diarrhea.

The opinions expressed are mine. My opinions may not reflect the views and opinions of McDonald, Mackay, Porter & Weitz, LLP. My opinions may not reflect the views and opinions of the course organizers, sponsors, or any professional association.
BLAME

- Anything that I say that is stupid, politically incorrect, insulting, or offensive is all me.

KEY POINT

- Put three attorneys in a room and get five opinions.

LET’S GET STARTED

(Please ask questions or I will talk in one long endless sentence with little to no punctuation.)

NICENESS MATTERS

- Be nice!!! People who are nice are less likely to be sued and less likely to be reported to the licensing board for possible disciplinary action.

DISRUPTIVE PHYSICIAN BEHAVIOR

- Always angry
- Kills messengers
- Inappropriate humor
- Inappropriate discussion
- Physical contact
- Tone and expression
- Cursing
- Overall “stress grenade”
DISRUPTIVE PHYSICIAN BEHAVIOR

- RELATIONSHIPS MATTER
- CEO TO THE JANITOR

OFFICE & SUPPORT STAFF

- WELL TRAINED
- EVEN TEMPERED & DIPLOMATIC
- ONGOING FEEDBACK
- LOOK THE PART
- PROCESSES FROM PHONE MESSAGES TO COMPLAINTS

APPEARANCES MATTER: PEOPLE AND PLACE

- CLEAN
- SMELLS AND ODORS
- NOT WORE OUT LOOKING
- ORGANIZED
- CALM AND UNDER CONTROL

BAG OF MEAT AND BONES?

- MAINTAIN A HEIGHTENED LEVEL OF SENSITIVITY AND REMEMBER THAT THE PATIENT IS A PERSON AND NOT A BAG OF MEAT AND BONES

FOLLOW YOUR CONSCIENCE

- IF YOU ARE HAVING A MENTAL DEBATE ON A PROPER COURSE OF ACTION YOU PROBABLY ALREADY KNOW THE ANSWER

DIVORCE YOUR EGO

- KNOW YOUR LIMITATIONS AND DON’T BE EMBARRASSED TO ASK FOR HELP OR ADMIT THAT SOMETHING IS OUTSIDE YOUR KNOWLEDGE OR SKILL SET
FAMILY MATTERS

- DON'T IGNORE THE FAMILY

Family Matters

- DON'T LEAVE THE IMPRESSION OF INFLEXIBLE OR DICTATORIAL
- WATCH OUT FOR CONFIDENTIALITY ISSUES
- BE RESPONSIVE, FOLLOW UP, LIVE UP TO PROMISES

COMMUNICATE

- LET THE PATIENT KNOW WHAT YOU ARE DOING AND WHAT YOU ARE GOING TO DO NEXT, HOW IT WILL FEEL, WHY IT'S IMPORTANT, WHAT YOU ARE LOOKING FOR, WHAT TO DO IF IT HURTS
- REPORTS ARE OFTEN DUE TO LACK OF COMMUNICATION
- REMEMBER THE BAG OF MEAT AND BONES LESSON

Communication is Listening

- PATIENTS WHO FEEL LIKE YOU HAVEN'T BEEN LISTENING TO THEM ARE MORE LIKELY TO COMPLAIN
- COMMUNICATION IS A LISTENING SKILL AND NOT JUST TALKING
- BAG OF MEAT AND BONES?

WALLS HAVE EARS

- PATIENTS ARE LISTENING
- "OOPS" "AH-OH" "THAT'S ODD"

Never Let Them See You Sweat

- PATIENTS ARE WATCHING
- PROJECT CONFIDENCE
- DEMONSTRATE COMPASSION
DOCUMENTATION

- Documentation is part of good care – it is hand in glove.

DOCUMENTATION

- Establishes a baseline so you know if there has been improvement.
- Fosters continuity of care by other providers.
- Is necessary for reimbursement.
- If done well it is your best defense against license complaints and law suits.

DOCUMENTATION

- A few prevalent beliefs:
  - In God we trust – everyone else must document.
  - If it wasn’t documented it didn’t happen.
  - If you can’t read it, you may as well have not written it.

DOCUMENTATION

- Some basics on “Paper” documentation:
  - No felt tips.
  - Caution with highlighters (yellow only).
  - Avoid leaving blanks on forms – line out or “X” out to avoid giving others an opportunity to.

DOCUMENTATION

- Some basics on “Electronic” documentation:
  - Be wary of auto-fill and defaults.
  - Don’t let artificial intelligence control.
  - Don’t be an EMR zombie.

DOCUMENTATION

- Show your work.
- Address the obvious.
- Note the unusual.
- “Rule out” diagnosis.
- Follow-up.
- Tickler system.
- Test results filing.
**DOCUMENTATION**

- BIG ROCKS, LITTLE ROCKS, GRAVEL, AND THEN SAND

**DOCUMENTATION**

- DON'T CORRECT OTHER PROVIDERS’ NOTES
- DON’T BLACK OUT
- DON’T WHITE OUT
- DON’T TEAR OUT

**DOCUMENTATION: CORRECTIONS & CHANGES**

- CORRECTIONS AND CHANGES OF RECORDS
  - SINGLE OR DOUBLE STRIKE THROUGH
  - INITIALED AND DATED
  - ADDENDUM OF LONG CORRECTION
  - ADDENDUM OF EXPLANATION
  - FOLLOW POLICIES AND PROCEDURES

**DOCUMENTATION: CORRECTIONS & CHANGES**

- CORRECTIONS AND CHANGES OF “ELECTRONIC” RECORDS
  - HAND WRITTEN CHANGES (SAME AS CHANGING PAPER RECORD)
  - ELECTRONIC CHANGES (WHAT’S ON YOUR SYSTEM?)
  - FOLLOW POLICIES AND PROCEDURES

**DOCUMENTATION**

- WATCH OUT FOR NON-STANDARD ABBREVIATIONS AND “GALLOWS HUMOR”
- CTD, PBBB, FLK, FLKWGLM....
- USE STANDARD ABBREVIATIONS OF FACILITY
- POST A STANDARD LIST FOR USE TO AVOID CONFUSION AND PROBLEMS

**DOCUMENTATION**

- SPOILATION AND TAMPERING
  - ADDING TO THE RECORD IMPROPERLY
  - DESTROYING ALL OR PART OF RECORD
  - REWRITING ALL OR PART OF RECORD
  - OMITTING SIGNIFICANT FACTS
  - DOCUMENTING INACCURATE INFORMATION

**DOCUMENTATION**

- DON'T CORRECT OTHER PROVIDERS’ NOTES
- DON’T BLACK OUT
- DON’T WHITE OUT
- DON’T TEAR OUT

**DOCUMENTATION: CORRECTIONS & CHANGES**

- CORRECTIONS AND CHANGES OF RECORDS
  - SINGLE OR DOUBLE STRIKE THROUGH
  - INITIALED AND DATED
  - ADDENDUM OF LONG CORRECTION
  - ADDENDUM OF EXPLANATION
  - FOLLOW POLICIES AND PROCEDURES

**DOCUMENTATION: CORRECTIONS & CHANGES**

- CORRECTIONS AND CHANGES OF “ELECTRONIC” RECORDS
  - HAND WRITTEN CHANGES (SAME AS CHANGING PAPER RECORD)
  - ELECTRONIC CHANGES (WHAT’S ON YOUR SYSTEM?)
  - FOLLOW POLICIES AND PROCEDURES

**DOCUMENTATION**

- WATCH OUT FOR NON-STANDARD ABBREVIATIONS AND “GALLOWS HUMOR”
- CTD, PBBB, FLK, FLKWGLM....
- USE STANDARD ABBREVIATIONS OF FACILITY
- POST A STANDARD LIST FOR USE TO AVOID CONFUSION AND PROBLEMS

**DOCUMENTATION**

- SPOILATION AND TAMPERING
  - ADDING TO THE RECORD IMPROPERLY
  - DESTROYING ALL OR PART OF RECORD
  - REWRITING ALL OR PART OF RECORD
  - OMITTING SIGNIFICANT FACTS
  - DOCUMENTING INACCURATE INFORMATION
**DOCUMENTATION**

- Avoid being judgmental and instead focus on behavior so as to minimize risk of angry patients or family members (i.e., “Drunk, noncompliant” versus “smell of alcohol and declined to perform exercises today”)

- Document patient complaints in quotes
- Document patient or family behavior that may be detrimental to care

**DOCUMENTATION**

- Eliminate bias in your records
  - Obstinate, abusive, belligerent, uncooperative, malingerer, noncompliant, complainer, obnoxious

**BOUNDARY ISSUES**

- CYA file or “covering your six”
  - Where to keep it
  - Benefits of notarization
  - Problems of discoverability

**HIPAA & Confidentiality**

- Need to know basis
- Sign in sheets
- Calling patients in lobby
- File access
- Hallway discussions
- Curbside chats
- Bar room rants
- Education, resources, forms, process
BOUNDARY ISSUES
- Social and Sexual Relationships
- Business Relationships
- Gifts
- Jokes, Gags, and Off the Cuff Comments

HALO EFFECT
- The nature of the provider-patient relationship often creates a “halo effect” in which the provider is perceived as incapable of doing wrong and wields psychological power in relation to the patient.

BE PROACTIVE
- Check currency of licenses, certifications, and facility registration
- Read the agency’s newsletter
- Surf the agency website
- Read the statute and the rules
- Conduct a wall to wall floor to ceiling office audit

CREDENTIALLING COORDINATOR
- Only as good as their education, training, and experience
- Garbage in; Garbage out
- They are only a caddie; the licensee is the golfer

THINK AND BE AWARE
- To avoid violations, you have to insert brain into the brain housing group – to try to understand the pertinent law and become aware of what is taking place around you

IT'S ABOUT AWARENESS AND THINKING
- This is a difficult time to be a health care provider. We live with litigious, highly sensitized people. To that end, you must protect yourself and exercise good judgment in dealing with all patients and their families. You have to be thinking and aware all the time. Situational awareness is key.
A PATIENT BILL OF RIGHTS CAN BE A COMPREHENSIVE DOCUMENT THAT EXPLAINS TO YOUR PATIENTS THAT THEY HAVE RIGHTS AND SHOULD EXPECT A CERTAIN LEVEL OF PROFESSIONALISM FROM YOU AND YOUR EMPLOYEES.

Most bills of rights contain the following information:

- Respect and nondiscrimination. You have a right to considerate, respectful and nondiscriminatory care from your doctors, other health care staff and employees.

- You have the right to accurate and easily understood information about your health plan, health care professionals, and health care facilities. If you speak another language, have a physical or mental disability, or just don't understand something, assistance will be provided to the best of our ability so you can make informed health care decisions.

- You have the right to know your treatment options and to participate in decisions about your care. Parents, guardians, family members, or other individuals that you designate can represent you if you cannot make your own decisions.

- You have the right to talk in confidence with health care providers and to have your health care information protected. You also have the right to review and copy your own medical record and request that your physician change your record if it is not accurate, relevant, or complete.

- You have the right to a fair, fast, and objective review of any complaint you have against your doctor, or other health care personnel. This includes complaints about waiting times, operating hours, the conduct of health care personnel, and the adequacy of health care facilities.
**Patient Bill of Rights**

- Such a document is empowering to patients.
- The key is that it must be a “true” document - meaning it will be enforced and the enforcement is communicated to the patient.

**Chaperones**

- When you should you use a chaperone?
  - In a perfect world – always for all patients?
  - In any state of undress – always for all patients?

**Chaperones**

- The role of the chaperone
  - To observe
  - To document
  - To assist when necessary

- The chaperone should independently document their attendance in the room, the time in and the time out.
- You should not be in the room alone without the chaperone.
- A family member of the patient is not an adequate chaperone under any circumstances.

**Prescribing**

- Maintaining objectivity in prescribing (friends, family, colleagues, and co-workers)
- Chronic pain (screens, contracts, referrals, special rules)
- Dosage, frequency, refills
- Drug-seeking behavior
- Government prescribing databases

**Alternative/Complementary Medicine**

- Extensive informed consent
- Special agency rules
- Risks, benefits & options
- Direct costs and opportunity costs
- Supporting literature
ADVERTISING PROBLEMS
- Print Ads
- Business Cards
- Signs
- Name Tags
- Website
- Radio Spots
- Television

AFTER THE BOARD COMES KNOCKING
- License

UNDER INVESTIGATION?

REACTING AND RESPONDING
- If you are notified of a complaint and asked to respond, don’t hit the panic button – it clouds judgment and is premature

DON’T BURY IT OR GO POSSUM

REACTING AND RESPONDING
- Don’t get angry
- Don’t send an instant response
**Reacting and Responding**

- Cooperate and RemEDIATE
- Gather Info and Witnesses

**Who Can You Talk To?**

- Cleric (Priest, Rabbi, Minister)
- Spouse (Sometimes)
- Attorney
- Potential Witnesses (Limited Purpose)

**Who Generally Not To Tell Details**

- Your Friends
- Your Coworkers
- Your Patients
- Your Family
- Acquaintances
- Strangers
  (Unless you want to invite them to the party and risk impeachment)

**Who Should You Possibly Notify**

- Malpractice Carrier
- Managed Care Plans
- Employer
- Facility Risk Manager

**How Do You Know Who To Notify**

- Read You Malpractice Policy
- Read Your Managed Care Contract
- Read Your Facility Policy and Procedures Manual
- Read Your Employment Contract
REACTING AND RESPONDING

- RESPOND IN A TIMELY MANNER

REACTING AND RESPONDING

- DON'T EXAGGERATE, EMBELLISH OR LIE
  - BAD CHARACTER CAN'T BE REMEDIATED !!!!

REACTING AND RESPONDING

- TAKE ADVANTAGE OF DUE PROCESS RIGHTS
  - INFORMAL SETTLEMENT CONFERENCE/SHOW
  - COMPLIANCE PROCEEDING
  - CONTESTED HEARING
  - APPEALS TO DISTRICT COURT AND BEYOND

QUESTIONS?

CONTACT TIM WEITZ AT:

- WEITZ@HEALTHLICENSEDEFENSE.COM
- WWW.HEALTHLICENSEDEFENSE.COM
- 512.322.9202
BREAKOUT SESSION I
HEALTH LAW AT THE CROSSROADS OF EPIDEMICS AND CATASTROPHES
FRIDAY, FEBRUARY 26, 1:00 PM - 2:45 PM

Grand Ballroom A

MODERATOR:
Victoria Green, MD, MHSA, JD, MBA, Past-President ACLM
Emergency Department Preparedness: Are We Ready for a Disaster?

Darren P. Mareiniss, MD, JD
Attending Physician, Department of Emergency Medicine
MedStar Franklin Square Medical Center
Clinical Instructor, University of Maryland School of Medicine

IOM Report - 2006

- Hospital-Based Emergency Care: At the Breaking Point
- Between 1993-2003, ED volume increased from 90.3 to 113.9 million (26%)
- During the same time, total number of hospitals decreased by 703
- Number of EDs decreased 425 over the same period
- Not only did volume increase dramatically, but report stated that patients appear older and sicker

IOM Report - 2006

- Medicaid patients, not able to gain access to care— the report showed 81 visits per 100 enrollees
- Health Care safety net and primary care for poor
- Overcrowding — 91% of EDs reported overcrowding — 60% daily and boarding patients was common
- Some causes:
  - (1) uninsured patient safety net, (2) refusal of practices to accept Medicaid, (3) principle site of access for patients with limited access, (4) door always open even when hospital is full, (5) unable to secure PCP appointments

The Emergency Department

- Emergency departments in US are stretched to capacity
- ED visits
  - 90.3 million ED visits in 1993
  - 113.9 million in 2003
  - 136 million in 2009 — increase of 50.6% in 16 years!!
  - Predicted 148 Million 2016 — 2.9% per year increase

U.S. News & World Report

- Crisis in the ER
- Inadequate numbers of hospitals or near closure
- Hospital staff are stressed to the max
- Lack of funding for capital improvement
- Economic incentive to operate at capacity
- Lack of negative pressure rooms

Is that a lot?

- Estimated population of the United States – 322 Million as of October 2015
- ED visits represent 44.7% of population size
- That is nearly 1 out of every 2 people!
- 281 ED visits per minute – 8,430 during this talk!
- 4.2% of doctors are EM physicians


United States Census Bureau at http://www.census.gov; ACEP Report Card
Survey Results Since Affordable Care Act 1/1/2014

- ACEP surveyed ED physicians from all 50 states
- Pollled – emailed 24,427 ACEP members March 2015
- N = 2,098
- 28% increased greatly
- 47% increased slightly
- 17% same
- 5% decreased slightly
- 0% decreased greatly
- 3% not sure

So, do you think the ED is ready for a disaster?

The Emergency Department

- Incomplete information
- Continual flow of patients
- Huge volumes/limited resources
- Critical cares / traumas
- Safety net for entire US health care system
- 2014 ACEP – ED Disaster Preparedness - C+
- 2014 ACEP – ED Overall Rating – D-

Ebola

- Unclear reservoir
- 5 types of Ebolavirus – 4 infect humans – first discovered Ebola River, Africa 1976
- Transmission – direct contact with bodily fluids or objects contaminated with fluids, primates, fruit bats, semen possibly after recovery
- Transmission only when patients are symptomatic
- Incubation period up to 21 days (average 8-10)
- Symptoms – fever, HA, myalgia, abdominal pain, vomiting, unexplained hemorrhage, diarrhea, fatigue

### Ebola 2014 – 4 Cases

- September 25 then 30, 2014 - Texas Presbyterian Hospital – Dallas, TX – September 2014
  - Emergency Department
  - Patient sent home initially and later diagnosed
- October 10 - Case #2- Healthcare worker in contact with index case
- October 15 - Case #3- Healthcare worker in contact with index case – had traveled October 10 via airplane to Cleveland and return trip October 13
- October 23rd – Healthcare worker returned from Guinea


### What Would an Infectious Disease Disaster Look Like?

- Ebola 2014 – 4 Cases
- Influenza Virus
- Influenza Clinical Course
- Pandemic Characteristics
- Pandemic History

### Influenza Virus

- Orthomyxoviridae - A, B and C
- Influenza A – 80-120 nm in diameter
- Negative sense RNA virus with 8 segmented strands in genome
- Influenza membrane glycoproteins
  - Hemagglutinin (HA) – 16 antigenic subtypes
  - Neuraminidase (NA) – 9 antigenic subtypes
- Influenza A in zoonotic hosts – aquatic birds, swine, horses, marine mammals - pandemic potential through reassortment – novel HA antigen

### Influenza Clinical Course

- Incubation period of 1-5 days
- Abrupt onset of headache, chills, nonproductive cough, myalgia, malaise and fever
- Uncomplicated course is self-limiting and symptoms dissipate within 1-2 weeks
- Increased risk of complications seen in pts > 65, pregnant women in 2-3rd trimester, pts with pulmonary disease, cardiovascular disease, immunosuppression, renal dysfunction, obese pts, and children 0-23 mo
- Potential pulmonary complications – viral pneumonia, secondary bacterial pneumonia – strep, pneumococci, b. influenzae and staph, aureus

### Pandemic Characteristics

- Lasts 12-36 months
- Up to 3 waves of disease
- Local epidemics last 6-8 weeks
- Virulence varies
- Attack rate of 30%

### Pandemic History

- Four Pandemics in the last 100 years:
  - 1918 (H1N1) – 549,000 – 1.7 million deaths in the United States – 2% mortality
  - 1957 (H2N2) – 70,000 deaths in the United States
  - 1968 (H3N2) – 34,000 deaths in the United States
  - 2009(H1N1) – 12,469 deaths
- 60.8 million cases and 274,304 hospitalizations

(Shrestha et al. 2011)
The challenge

Table 1. Number of Episodes of Illness, Healthcare Utilization, and Death Associated with Moderate and Severe Pandemic Influenza Scenarios

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Moderate (1957 &amp; 1968)</th>
<th>Severe (1918 &amp; 1957)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>2.0 million (10%)</td>
<td>10.0 million (50%)</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>4.0 million (20%)</td>
<td>10.0 million (50%)</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>8.0 million (40%)</td>
<td>10.0 million (50%)</td>
</tr>
<tr>
<td>ICU Care</td>
<td>12.0 million (60%)</td>
<td>14.0 million (70%)</td>
</tr>
<tr>
<td>Mechanical Ventilation</td>
<td>62,875</td>
<td>70.500</td>
</tr>
<tr>
<td>Deaths</td>
<td>288,000</td>
<td>1,945,000</td>
</tr>
</tbody>
</table>

*Percentages based on population from past pandemics in the United States. Note that these estimates do not include the potential impact of intervention and worldwide during the 21st century pandemic.


National Requirements of a 1918-Type Pandemic

- 197% of hospital beds
- 461% of ICU beds
- 198% of available ventilators


Worst-Case Scenario: 1918-Type Pandemic

- Insufficient beds
- Insufficient ICU beds
- Insufficient ventilators
- Insufficient surge capacity
- Insufficient ED resources

Health Care Consequences

- Disproportionately high infection rate among health care providers
  - 22% of SARS infections in China were health care workers
  - 43% of all infections in Canada were among health care workers
  - 1918 pandemic – anecdotal evidence that health care workers were disproportionately infected
  - High number of infected health care workers during 2014-15 Ebola outbreak – 881 confirmed infections

Fear of Infection May Affect Response

- Public Health Department Survey – Balicer et al 2006 *BMC Public Health*
- Survey of 3 county health departments in Maryland – 308 respondents (68% response rate)
- 163/303 responded that they would likely report to work – 53.8%
- However, clinical staff (n=102), rather than technical and support staff were found to be more likely to report to duty (OR: 2.5, CI 1.3-4.7)
- Perceived importance to the response effort was the most important predictor of whether a worker would be willing to report

What do we do?
Crisis Standards of Care

- AHRQ report 2005 - “Altered Standards of Care” – renamed Crisis Standards of Care
- “The term “altered standards” has not been defined, but generally is assumed to mean a shift to providing care and allocating [care]… in a way that saves the largest number of lives in contrast to the traditional focus on saving individuals.”

Graded Response

Graded Response: Maximize Capacity

- Beds:
  - Alternate Care Spaces
    - Turn away low acuity patients
    - Cancel elective procedures
    - Repurpose space – PACU as ICU
- Staffing
  - Overtime
  - Recalling staff from vacation and leave
  - Agency staffing
  - Volunteers from public
- Reuse Equipment
- Provide PPE / training

Graded Adjustment of Care

- Change nursing/patient ratio
- Use non-healthcare workers for basic care
- Cancel all elective appointment / procedures
- Check vital signs based on clinical condition
- Minimize labs/radiology
- Expand scope of practice – PAs, Nurses, Pharmacists, etc.
- Allocate anti-viral, vaccine and abx to select patients – CDC guidance
- Reserve admission only for severely ill patients
- Allocate ventilators/ICU beds

Example - ICU Beds: EMCC

- Rubinson et al - Task force for Mass Critical Care Summit Meeting, 2007
- Method for expanding ICU capacity by expanding scope of practice in a graded manner
- Utilizing nonintensivist physicians and nurses without ICU experience
  - 6 patients/1 nonintensivist and 4 nonintensivist for one intensivist
  - 1 non-critical care nurse/2 patients and 1 critical care nurse for 3 nurses

Emergency Mass Critical Care

- Prepare for 10 days of EMCC, use nonintensivist physicians, nurses and expand into ward; increase capacity by 300%
- Reallocation of resources, if required, should include all patients
- Expand ICUs onto specific wards, use recovery room, adapt, conserve, reuse equipment and reallocate
  Substitute Adapt Conserved Reused Reallocated
What happens when resources are gone?

- When we cannot stretch resources further:
  - ICU exclusion and allocation of vents/beds – favor patients most likely to survive
  - EMS exclusion
  - Limit admissions
  - Most good for the greatest number of people

### SOFA Score

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>PaO2/FIO2</td>
<td>&gt;400</td>
<td>&lt;300</td>
<td>&lt;200</td>
</tr>
<tr>
<td>Platelets</td>
<td>&gt;150</td>
<td>&lt;150</td>
<td>&lt;50</td>
</tr>
<tr>
<td>Total Bilirubin</td>
<td>3.3-9</td>
<td>3.3-9</td>
<td>6.1-9</td>
</tr>
<tr>
<td>Hypotension and vasopressors</td>
<td>MAP&lt;70</td>
<td>Dopap&gt;5 ug/kg/min</td>
<td>Dopap&gt;5 ug/kg/min or Norep or Epinephrine&gt;1 ug/kg/min</td>
</tr>
<tr>
<td>GCS</td>
<td>13-14</td>
<td>10-12</td>
<td>6-9</td>
</tr>
<tr>
<td>Creatinine</td>
<td>1.2-1.9</td>
<td>2-3.4</td>
<td>3.5-4.9</td>
</tr>
</tbody>
</table>

### TMCC – Exclusion Criteria

- SOFA score with >80% mortality
  - SOFA >15, > 5 for 5 days or 2 or 6 organ failure
- Severe and chronic disease:
  - very severe trauma;
  - severe burn (>40% TBSA; >60 yr; inhalation); cardiac arrest - un-witnessed; witnessed and not responding to Rx; recurrent;
  - Severe baseline cognitive impairment;
  - Advanced untreatable neuromuscular disease
  - mit CA;
  - end-stage heart, lung (COPO, CF, PF, Pm HTN) or liver disease (Child Pugh 2-7) age > 55

### State Guidelines for CSC

- 2008 GAO – States had not begun guidelines b/c of difficulty addressing the medical, ethical and legal issues
- DHHS website show publically available guidelines – DE, DC, KS, LA, MI, ND, OR, SC, TX

### Michigan Uses Different SOFA scores

Michigan - ICU Triage Decisions

- Made by an independent triage officer or team
- Decision not made by treating physician
- Most guidelines have an appeal process – family can appeal decision to the Clinical Review Committee:
Additional Considerations: Antibiotics / Anti-viral / Oxygen

- CDC has had prior guidelines on anti-viral/vaccine allocation
- Pandemic also may result in secondary PNA in 15-20% of patients
  - Streptococcus pneumoniae and Staphylococcus aureus most common
  - Michigan plan suggests allocation of antibiotics to confirmed cases of PNA and based on SOFA
- Oxygen allocation scheme if shortage
  - Ventilated Patients
  - Adults with Oxygen sat < 86% on RA
  - Pediatric Patient > 1 with RA sat < 88% or RR > 40
  - Pediatric Pt with RA sat < 88% or RR > 60
  - Pt. with PNA and hypoxia

ACEP 2013 Report – CSC Triggers

- Possible triggers:
  - Formal declaration of an emergency by local, regional, state, or national authority;
  - Loss of essential services, including electricity, water or the supply chain;
  - Loss of infrastructure, including facilities;
  - Exceptional surge in numbers and severity over a short period of time;
  - Shortage of ventilators;
  - Shortage of medication or other supplies; or
  - Shortage of providers.

What do local ED plans really look like?

- Determination of a disaster based on needs >> resources
- Declaration of onsite “code yellow” disaster by Chief Administrator
- Form HCC (Hospital Command Center) or ICC
- Create alternate care sites – cafeteria, lobby, conference rooms, unit lobbies, local facilities MOU (local CC)
- Triage patients
- Allocate ICU beds and supplies in collaboration with Ethics committee when CSC required

Federal – Public Health Service Act

- After consulting with such public health authorities “as may be necessary,” the DHHS Secretary finds:
  - “(1) a disease or disorder presents a public health emergency; or
  - (2) a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists”
Public Health Service Act

- **PHS Act during an emergency:**
  - Isolation and quarantine – entry into the US or movement between states
  - Utilize the Strategic National Stockpile
  - Waive federal regulations – allow use of unapproved drug, biologic or device for a military emergency, domestic emergency or during a declared emergency
  - Waiver of individual participation requirements of Medicare/Medicaid, actions under EMTALA, and sanctions for HIPAA privacy violations

Section 1135 Social Security Act

Federal – Public Health Powers

- **ESF # 8 resources can be activated** (1) by declaration of a public health emergency by Secretary of DHHS; (2) under the Biological Incident Annex; or (3) under the Stafford Act
- NIH, CDC, SNS, US Public Health Service, NDMS
- The support of state, local and tribal jurisdictions focuses on:
  - Assessment of public health/medical needs
  - Public health surveillance
  - Medical care personnel
  - Medical equipment and supplies

The Model State Emergency Health Powers Act

- A state of public health emergency may be declared by the Governor upon occurrence of a public health emergency. (21 states)
- A public health emergency is an occurrence or imminent threat of an illness or health condition that:
  1. Is believed to be caused by the following:
     - (i) bioterrorism;
     - (ii) the appearance of a novel or previously eradicated infectious agent or biological toxin;
     - (iii) [natural disaster];
     - (iv) [chemical attack or accidental release]; or
     - (v) [nuclear accident];
  2. Poses a high probability of any of the following harms:
     - (i) a large number of deaths in the affected population;
     - (ii) a large number of serious or long-term disabilities in the affected population;
     - (iii) [possible exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population].

Civil Liability

- Negligence: (1) duty; (2) breach because of a failure to meet the applicable standard of care; (3) harm; and (4) causal link between the breach and the harm
- “Standard of care is defined by reference to a physician using the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing, good medical practice within the area of specialty practice and reasonable, customary and accepted care under the circumstances”
  - Vicarious liability
    - EMTALA, HIPAA, privacy & confidentiality

Protections – State Laws

- 50 state jurisdictions have a variety of laws regarding immunity
- Good Samaritan laws – uncompensated & at the scene
- Protections usually do not apply to:
  - Willful or reckless conduct
  - Gross negligence
  - Criminal action

Protections – Emergency Management Assistance Compact

- Enacted in all states
- Triggered by gubernatorial declaration of disaster and a request for aid
- Provides licensing reciprocity
- Civil immunity to any “party state or its officers or employees” offering aid to another state – shall not be liable for an act or omission in good faith
- Does not cover willful misconduct, gross negligence or recklessness
**Protections – Volunteer Protection Act**

- Federal legislation – Covers uncompensated volunteers of NGO or government entities
- Must act within the scope of responsibilities
- Property licensed and authorized by the state
- Emergency does not need to be declared
- Does not cover willful or criminal misconduct, gross negligence or reckless misconduct

**Protections – Uniform Emergency Volunteer Health Practitioner Act**

- Adopted – UT, NV, CO, DC, NM, TX, AR, ND, OK, LA, IN, IL, KY and TN
- Licensed health practitioners in a state where an emergency declaration is in effect
- Compensation may be allowed, but no pre-existing employment relationship
- Covers vicarious liability
- Does not cover willful, reckless, wanton, grossly negligent or criminal conduct

**Protections – Model State Emergency Health Powers Act**

- Adopted by 38 states and D.C. – created in 2001
- 804(b)(2) – 23 states
  - Any person who “renders assistance or advice at the request of the state or its subdivisions”
  - Does not cover gross negligence or willful misconduct
- 608(b) – 13 states
  - Any out-of-state emergency health care provider appointed by the Public Health Authority is not liable
  - Except reckless disregard for consequences so as to affect the life or health of the pt.

**Sovereign Immunity**

- Federal, state and local governmental entities and their employees are immune from tort suits
- Limited waivers of this immunity – e.g., FTCA, state TCAs
- However, discretionary functions within the scope of duties typically create immunity

**Gaps – Individuals Not Covered**

- Depends on state law
  - Providers continuing to work in an affected area
  - Providers acting outside the scope of their expertise may not be covered – some states allow, i.e., MI, MD and MA
  - Compensated providers

**Gaps – Conduct Not Covered**

- Criminal conduct – manslaughter & murder
- Gross negligence – an intentional failure to perform a manifest duty in reckless disregard of the consequences as affecting the life or property of another
- Willful misconduct – conscious intent to undertake the injurious activity with a realization of the likelihood of harm
Crisis standards may involve re-allocating or not offering life-saving interventions.

“When we willfully and knowingly withdraw or withhold life support, knowing there maybe a bad outcome, we tread that line of willful misconduct.”

Cheryl Starling – California Dept. of Public Health – IOM Workshop 2010

Two Potential Solutions

- Broader legislation providing immunity for:
  - Triage decisions
  - Crisis standards of care and withdrawing/treating life-saving interventions
  - Compensated providers in disaster zone
  - Care outside the scope of expertise – e.g., MI, MA, MD
  - Immunity for institutions providing care
- State or federally deputized doctors – sovereign immunity for discretionary actions, regardless of willfulness

Virginia and Maryland-Broad

- Virginia - Va. Code Ann 8.01-225.02
  - No liability for any injury or wrongful death from delivery or withholding of health care when (1) a state or local emergency has been declared and (2) the emergency caused a lack of resources preventing healthcare providers from rendering standard care
  - “[a] healthcare provider is immune from civil or criminal liability if the healthcare provider acts in good faith and under a catastrophic health emergency.”

References

- Okie S, Dr. Pou and the Hurricane – Implications for Patient Care during Disasters. N Engl J Med 2008;358(1);1-5
References

- United States Census Bureau, Population Clock available at: http://www.census.gov/popclock/ (last visited October 22, 2015)
BREAKOUT SESSION II
CURRENT CONTROVERSIES IN PEDIATRICS

FRIDAY, FEBRUARY 26, 3:00 PM - 5:00 PM

Grand Ballroom A

MODERATOR:
Martin J. Stillman, MD, JD, FCLM
VACCINATIONS & EXEMPTION ISSUES

DAN W BOLTON, III, DO, ESQ
ATTORNEY & PHYSICIAN
2014

GOVERNMENTAL COMPLIANCE
- STATE & FEDERAL PUBLIC HEALTH LAWS
- POLICE POWERS
- SCHOOL POLICIES
- EMPLOYMENT RESTRICTIONS
- IMMIGRATION

PUBLIC POLICY PROMOTION
- CDC
- PHARMACEUTICAL INDUSTRY
- MEDICAL SOCIETIES
- PRIVATE INTEREST GROUPS
- WORLD HEALTH ORGANIZATION

CONSTITUTIONAL PROTECTIONS
- PRIVACY RIGHTS
- RIGHT OF PARENTING
- RELIGIOUS RIGHTS
- REFUSAL OF MEDICAL CARE

PHYSICIAN CONCERNS
- STATE MEDICAL BOARD
- STATE PUBLIC HEALTH REGULATIONS
- PROFESSIONAL SOCIETIES
- PROFESSIONAL LIABILITY
- PHYSICIANS PROFESSIONAL OPINION
Legal (and a few Medical) Barriers to Contraception Access for American Teenagers

John Goldenring, MD,MPH,JD,FAAP,FSAHM
Medical Director and Medical-Legal Consultant
San Diego, CA

Right of Consent for US Teens

- Age of Majority
- Mature Minor
- Parent
- Military
- Married
- How young?

State Law Summary

CA = universal consent  TX = Married only — no State funds to counsel

Specific Consent for Contraception for US Teens

- 21 states and the District of Columbia explicitly allow all minors to consent to contraceptive services.
- 25 states explicitly permit minors to consent to contraceptive services in one or more circumstances.
- 3 states allow minors to consent to contraceptive services if a physician determines that the minor would face a health hazard if she is not provided with contraceptive services.
- 21 states allow a married minor to consent to contraceptive services. 6 states allow a minor who is a parent to consent.
- 6 states allow a minor who is or has ever been pregnant to consent to services.
- 11 states allow a minor to consent if the minor meets other requirements, including being a high school graduate, reaching a minimum age, demonstrating maturity or receiving a referral from a specified professional, such as a physician or member of the clergy.
- 4 states have no explicit policy on minors’ authority to consent to contraceptive services.

Emergency Contraception

- Now 4 products available
- OTC per FDA ruling in 2014
- Only age 17 and over
- Why 17?? Over half teens sexually active by this age

Emergency Contraception Laws

- 13 states and the District of Columbia require hospital emergency rooms to provide emergency contraception related services to sexual assault victims.
- 6 states allow pharmacists to refuse to dispense emergency contraception if they are religiously opposed.
- 9 states allow pharmacists to dispense emergency contraception without a prescription under certain conditions.
- 7 states allow pharmacists to distribute it when acting under a collaborative-practice agreement with a physician.
- 5 states, including 3 that also allow pharmacists the collaborative-practice option, allow pharmacists to distribute emergency contraception in accordance with a state-approved protocol.
- 4 states direct pharmacies to fill all valid prescriptions.
- 9 states allow pharmacists to dispense emergency contraception without a physician’s prescription but only under certain conditions.
- 3 states allow pharmacies to refuse to dispense emergency contraception.
- A hospital may refuse based on religious or moral beliefs to provide emergency contraception when requested by a woman who has been sexually assaulted.
- A hospital may contract with an independent medical professional in order to provide the emergency contraception services.
- A hospital may refuse to provide emergency contraception if it is inconsistent with its religious beliefs or moral convictions.
- The law explicitly excludes emergency contraception in Texas.
- The law does not include an enforcement mechanism.
- University of California San Francisco is developing a tool to provide information about emergency contraception in California.

State Contraceptive Laws

- 13 states and the District of Columbia require emergency rooms to provide emergency contraception related services to sexual assault victims.
- 6 states allow pharmacists to refuse to dispense emergency contraception if they are religiously opposed.
- 9 states allow pharmacists to dispense emergency contraception without a prescription under certain conditions.
- 7 states allow pharmacists to distribute it when acting under a collaborative-practice agreement with a physician.
- 5 states, including 3 that also allow pharmacists the collaborative-practice option, allow pharmacists to distribute emergency contraception in accordance with a state-approved protocol.
- 4 states direct pharmacies to fill all valid prescriptions.
- 9 states allow pharmacists to dispense emergency contraception without a physician’s prescription but only under certain conditions.
- 3 states allow pharmacies to refuse to dispense emergency contraception.
- A hospital may refuse based on religious or moral beliefs to provide emergency contraception when requested by a woman who has been sexually assaulted.
- A hospital may contract with an independent medical professional in order to provide the emergency contraception services.
- A hospital may refuse to provide emergency contraception if it is inconsistent with its religious beliefs or moral convictions.
- The law explicitly excludes emergency contraception in Texas.
- The law does not include an enforcement mechanism.
- University of California San Francisco is developing a tool to provide information about emergency contraception in California.

Emergency Contraception Laws

- 13 states and the District of Columbia require hospital emergency rooms to provide emergency contraception related services to sexual assault victims.
- 6 states allow pharmacists to refuse to dispense emergency contraception if they are religiously opposed.
- 9 states allow pharmacists to dispense emergency contraception without a prescription under certain conditions.
- 7 states allow pharmacists to distribute it when acting under a collaborative-practice agreement with a physician.
- 5 states, including 3 that also allow pharmacists the collaborative-practice option, allow pharmacists to distribute emergency contraception in accordance with a state-approved protocol.
- 4 states direct pharmacies to fill all valid prescriptions.
- 9 states allow pharmacists to dispense emergency contraception without a physician’s prescription but only under certain conditions.
- 3 states allow pharmacies to refuse to dispense emergency contraception.
- A hospital may refuse based on religious or moral beliefs to provide emergency contraception when requested by a woman who has been sexually assaulted.
- A hospital may contract with an independent medical professional in order to provide the emergency contraception services.
- A hospital may refuse to provide emergency contraception if it is inconsistent with its religious beliefs or moral convictions.
- The law explicitly excludes emergency contraception in Texas.
- The law does not include an enforcement mechanism.
- University of California San Francisco is developing a tool to provide information about emergency contraception in California.

Professional Barriers

- Tracey A. Wilkinson, MD, MPH; Nisha Fahey, BA; Emily Suther, MA; Howard J. Cabral, PhD, MPH; Michael Silverstein, MD, MPH
- Access to Emergency Contraception for Adolescents

Implantable Contraceptives

- Most effective and safe method (ACOG)
- Insurance must cover under ACA
- BUT – what about life after Hobby Lobby?(20 States already allowed exemptions to mandates)
- AND

We Didn’t Get the Memo!

- Primary Care Physicians’ Concerns May Affect Adolescents’ Access to Intrauterine Contraception

  Susan E Rubin, MD, MPH, and Susan Markens
  http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3913563/

  PCPs and Obs believe STD risk trumps – which is now disproven
From a school system not so far away

• CONDOM
  » WARS!

Selected Resources

• Gutmacher Institute

• Center for Adolescent Health Law
  www.cahl.org/about/leadership

• http://www.advocatesforyouth.org/about-us/programs-and-initiatives/738?task=view
JOINT GENERAL SESSION III
INNOVATIVE SOLUTIONS TO HEALTH POLICY PROBLEMS

SATURDAY, FEBRUARY 27, 8:00 AM - 9:45 AM

Grand Ballroom A

MODERATOR:
Richard S. Wilbur, MD, JD, FCLM
Is it time for revolution in health innovation?

Clay Johnston, MD, PhD
Dean, Dell Medical School

Broken health system

Cost per new drug
Cost of healthcare
Growth of healthcare costs compared to CPI

Cost of healthcare
Per person spending

US life expectancy

Investment

1. U.S. is the number one spender on healthcare in the world

But only 34th in health outcomes
10 Glaring Examples

10 Costs of care are out of control and only going up

9 No one pays for prevention

8 It’s nearly impossible to find a doctor

7 No one reminds you to take your meds

6 Office visits are way too short
1. Hospital gowns expose your rear

2. Can’t email your doctor

3. Seeing more of the back of your doctor’s head

4. Can’t find an apple in a vending machine

5. Flu management requires an office visit

Broken healthcare delivery system
Invested in the status quo

Doing more, rather than doing better

Treating the sickest rather than promoting health

Resistant to technology and other approaches to enhance efficiency

Funds
90% education

Funds
50% research

Care

Value

$
Business Comparison

Imagine someone else paying restaurants per pound for a meal on your behalf

Broken community health system

1. HIV/AIDS
2. Drug overdose, unintentional
3. Self-inflicted injuries, all mechanisms
4. Breast cancer
5. Pancreas cancer

1. Violence/assault, all mechanisms
2. Drug overdose, unintentional
3. HIV/AIDS
4. Self-inflicted injuries, all mechanisms
5. Alcohol use disorders

Broken research system
Rethink Research

Rethink Care Delivery

Rethink Innovation

Rethink Community

Rethink Health

Rethink Academia
Rethink Everything

Dell Medical School at UT Austin

Opportunity to start from scratch

First school in decades to be built at a Tier 1 research university

Unprecedented partnership with our community
Austin: a hub for innovation, technology and entrepreneurism

Can we create a better ecosystem for health innovation?

Faster Innovation Cycles: Lean Start-Up Model

Case study: Caring Wisely program
UC San Francisco

Ultimate goal is to increase value to society by improving quality and reducing waste
Mechanism for achieving this is through initial incremental gain within specific care delivery systems

Program criteria:
Scalable within and beyond UC San Francisco
Must show potential for savings of >$200k within first year
Preference given to those that improve health

Crowd sourcing ideas and proposals

IT and implementation support provided

Caring Wisely program results:

143 Program ideas generated in the first round
143 Program ideas generated in the first round
3 selected

Program 1
IV to PO switch
Pharmacist leader

Program 2
“Nebs no more after 24”
Physician leader

Program 3
Reduction of RBC Transfusions
Nurse leader

Total cost Caring Wisely Program:
$225,000

Total savings:
$4,000,000
Requirements for an improved health ecosystem

- The product is value
  \[ \text{value} = \frac{\text{quality}}{\text{cost}} \]

- Value is measurable

- Value is embraced by culture

- Barriers to aligning incentives are minimized

- Participants can be innovators
Barriers to aligning incentives are minimized
Participants can be innovators
Scaling is possible

Innovation is built into the funding model

Focus on making Austin a model healthy city

What needs to happen

Create funding streams based on health value
New partnerships with self-insured businesses, insurers, hospitals, local health districts and CMS
Requires orchestration of multiple disjointed entities

Better data
Not just for prioritization, but also to assess impact on an ongoing basis
New approaches to education
Physicians who are not just willing partners but leaders in creating better systems

Encourage interdisciplinarity
Diverse, creative minds coming together in new ways
- Design Institute for Health

Creative partnerships
Community Hospitals & Doctors
Community Public Health Entities & Nonprofits
Academic Hospitals & Doctors
Government / Employers
People
Entrepreneurs
Care Providers
Businesses
Communities
Is it time for revolution in health innovation?
BREAKOUT SESSION III

PHYSICIANS, DENTISTS, AND LAWYERS AS DEFENDANTS (ETHICS)

SATURDAY, FEBRUARY 27, 10:00 AM - 11:50 AM

Grand Ballroom A

MODERATOR:
Dale H. Cowan, MD, JD, FCLM
Lawyers and Physicians: Racial Hygiene During The Third Reich

Karin Waugh Zucker, MA, JD, LLM, FCLM, Professor
Army - Baylor University Graduate Program in Health and Business Administration
ameddja@att.net
C. Scott Kruse, PhD, FACHE, Assistant Professor
Texas State University, San Marcos, TX
Martin J. Boyle, JD
Army - Baylor University Graduate Program

The views expressed herein are those of the authors only and do not represent official policy of the Department of Defense or the Department of the Army.

Deontological Theory

- Immanuel Kant (Kantianism)
- An obligation-based theory
  - (Gk.) deon = ought; deontology is the study of moral obligation
- One acts only from those personal rules that one can, at the same time, will to be moral laws.
- Persons must not be treated solely as a means to an end; persons are ends in themselves.

Utilitarianism

- John Stuart Mill
- Consequentialist-based theory
- An action or practice is right if it produces maximum value, i.e., the greatest balance of good over harm.
- We promote human welfare by minimizing harms and maximizing benefits.

Mindset?

- Power: Health and, perhaps strangely, education
- Volk / we / us - were not / are not the other
- Eugenics – Racial Hygiene
- Hippocratic Oath – Gesundheit Oath – one of the many professional oaths required during the period of the Third Reich (not to patients, not to medicine, but to Hitler and the volk)
- Beneficence and nonmaleficence – Acting on behalf of the volk, the Fuhrer, German law

Agenda

- Deontology and utilitarianism
- Power of the professions
- Lawyers; then doctors; + T-4
- Continuously evolving laws - Nürnberg
- Euthanasia to The Final Solution
- "We were only following orders"

Ethics during the time of the Third Reich was primarily utilitarian. The Reich was regarded as the patient. The Reich, not the actual patient, was the entity to whom doctors and lawyers were beneficient; nonmaleficent; and, arguably, just. This led to the killing of those who were a financial drain on the Fatherland.
Nürnberg Laws – 1933 - 1935

1. Law for the Restoration of the Professional Civil Service – excluded Jews and other non-Aryans from many organizations and professions. Slightly later, Jewish students, physicians, and lawyers were targeted.

2. Law to protect German Blood and Honor – forbade those with German-related blood from marrying Jews or having sexual relations with them. Such marriages that took place before the passage of the law remained in effect; however, Germans were encouraged to divorce their non-German spouses.

Categories of Jews / Jewishness

Full Jew – those who practice Judaism or those who had at least 3 Jewish grandparents, regardless of religious practice.

First Class / half – those who had 2 Jewish grandparents; did not practice Judaism; and did not have a Jewish spouse.

2nd Class – those who had 1 Jewish grandparent and did not practice Judaism.

It is simplistic, but the lawyers changed the laws; the physicians followed the laws:

- Infanticide
- Euthanasia
- Mass Murder

And those of T-4 worked to convince the public this was correct, i.e., right.

The Doctors’ Trial at Nürnberg
The Doctors’ Trial

-20 of the 23 defendants were physicians; 3 were administrators, apparently similar to our military’s medical service corps officers. All were tried in the 1st of the 12 trials known as the Subsequent Nürnberg Trials, held before the Nürnberg Military Tribunal; December 9, 1946 through August 20, 1947. The infamous Dr. Mengele had evaded capture.

-Indictment: 1) Criminal conspiracy; 2) war crimes; 3) crimes against humanity; 4) membership in a criminal organization. --Count 1 was held to be beyond the jurisdiction of the court.

The Doctors’ Trial (cont.)

-War Crimes explained: murder by injection and overdose of those in nursing homes, hospitals, and asylums in the Euthanasia Program; murder, torture, and cruelty in medical experiments without consent of prisoners in concentration camps; and mass murder in the camps.

-Verdicts: 7 were acquitted; 6 received sentences for a term of years; 5 received life sentences; and 5 were condemned to death.

-The text of the Nürnberg Code is part of the decision in this case.


The Jurists’ Trial / The Trial of Lawyers and Judges at Nürnberg

-3rd of 12 trials before the Nürnberg Military Tribunal; March 5 to December 4, 1947

-3 of the highest ranking were not tried: Fritz Gürtner, Minister of Justice died in 1941; Georg Thierack, who followed him, as Minister of Justice, committed suicide in 1946; and Roland Freisler, was killed in a bombing raid on Berlin in 1945.

-Indictment: 1) Criminal conspiracy – dropped as outside the court’s jurisdiction; 2) war crimes – abuse of the judicial process; 3) war crimes; 4) membership in a criminal organization.

The Jurists’ Trial at Nürnberg (cont.)

-All 16 defendants pleaded not guilty.
-1 committed suicide before trial; 1 trial resulted in a mistrial and the defendant died shortly thereafter; 4 were acquitted; 6 received 10 years imprisonment or less; and 4 were sentenced to life imprisonment.
### War Crimes

#### A. Experiments

- **High-Altitude Experiments**: "For the benefit of the Luftwaffe, to investigate the limits of human endurance and existence at extremely high altitudes."
- **Freezing Experiments**: "To investigate the most effective means of treating persons who had been severely chilled or frozen."
- **Malaria Experiments**: "To investigate immunization for and treatment of malaria."
- **Lost (Mustard) Gas Experiments**: "To investigate the most effective treatment of wounds caused by lost gas, commonly called mustard gas."
- **Sulfanilamide Experiments**: "To investigate the effectiveness of sulfanilamide."
- **Bone, Muscle, and Nerve Regeneration and Bone Transplantation Experiments**: "To study regeneration and bone transplantation from one person to another."
- **Sea-Water Experiments**: "To study various methods of making sea water drinkable."
- **Epidemic Jaundice Experiments**: "To investigate the causes of, and inoculations against, epidemic jaundice."
- **Sterilization Experiments**: "To develop a method of sterilization which would be suitable for sterilizing millions of people with a minimum of time and effort."
- **Tuberculosis Experiments**: "To investigate the effectiveness of typhus and other vaccines."
- **Experiments with Poisons**: "To investigate the effect of various poisons on human beings."
- **Legionary Bacterial Experiments**: "To test the effect of various pharmaceutical preparations on phosphorus burns.

#### B. Murder of civilians and nationals of countries at war with the Reich

- **Murder of 112 Jews to complete a skeleton collection for the Reich University of Strasbourg.**
- **Murder and/or mistreatment of Polish nationals, many of whom were purposefully infected with incurable tuberculosis.**

#### E. Euthanasia Program of the Reich and the mass extermination of the Jews

- 1. Murder, torture, and other atrocities
- 2. Murder and/or mistreatment of tens of thousands of Polish nationals
- 3. Euthanasia program
What Are Medical Legal Risks for Cruise Ship Doctors?
Paul Blaylock, MD, JD, FCLM

- 1. 8-9am & 4-5pm? What kind of job is that?
- 2. What does a cruise ship doctor actually do?
- 3. What medical legal decisions are made daily?
- 4. What lawsuits have been filed against cruise ship doctors?
FRAUD ALLEGATIONS AGAINST THE HEALTH CARE PROVIDER: A PERSONAL EXPERIENCE: WHAT IF YOU FIND YOURSELF ON THE RECEIVING END OF PROSECUTORIAL MISCONDUCT?

MORRIS V. SPITZER
07-CV-47931

MY AUDIT HISTORY

AUDIT 0887-1191  $1,376.13
AUDIT 03281-7406  $2,293.86
AUDIT 98870-7032  $6,616.94

THE TOTAL OF ALL PRIOR COMPREHENSIVE AUDITS ~ $23,179.99

AUGUST 2002 3rd MEDICAID AUDIT

2005 THE AG, SPITZER, RUNS FOR NEW YORK GOVERNOR
THE ANTISPUTZER SENTIMENT

APRIL 2006. I AM INDUCTED
ARRAIGNMENT IN CRIMINAL COURT

"WHEN THE ELECTION IS OVER YOUR PROBLEMS ARE OVER"

THE PROFFER AT THE OFFICE OF THE ATTORNEY GENERAL: ELIOT SPITZER

"THE PEOPLE UPSTAIRS WANT THIS CASE TO CONTINUE"

THE CRIMINAL TRIAL: JUNE 2007, REFUSING JURY TRIAL ON A 3- (FELONY)

CRIMINAL TRIAL MISCONDUCT:

MY CRUMBS ARE "LOST"
NO WITNESS LIST PROVIDED
ROSAEO MATERIAL WITHHELD
SECRET WITNESS: DR. GOLBER
PROSECUTIONS CLOSING SECCOMATION
PROSECUTOR RETIRES BEFORE VERDICT ANNOUNCED

WHO ARE YOU GOING TO CALL WHEN YOU WANT TO SUE ELIOT SPITZER ?????

PROSECUTORIAL PROTECTIONS

ABSOLUT E IMMUNITY
QUALIFIED IMMUNITY
PROBABLE CAUSE
ARGUABLE PROBABLE CAUSE
HARMLESS ERROR
11/16/2007
FEDERAL CIVIL
RIGHTS LAWSUIT
42 U.S.C. SECTION
1983

MALICIOUS PROSECUTION
FALSE ARREST
STIGMA PLUS CLAIM
DENIAL OF A FAIR TRIAL DUE TO FABRICATION OF THE EVIDENCE

FEDERAL MAGISTRATE
RULINGS
1. RELEASE OF GRAND JURY TRANSCRIPTS UNREDacted.
2. DEPOSITIONS WILL TAKE PLACE
3. THERE WILL BE DISCOVERY

DISCOVERY
20,000 DOCUMENTS TURNED OVER
“SMOKING GUN”: THE EVII
PROSECUTORS E-MAILS
SPOLIATION OF EVIDENCE
“ILLUSTRATIVE BILLINGS”
GJ. EXHIBIT #7
GJ. EXHIBIT #11: SUPER PATIENT
GRAND JURY ORIGINALS LOST
DATE ALTERATIONS EXECUTED
CHECK DATA DELETED

ARE THE TOOTH NUMBERS ( A MANDATORY FIELD ON ALL DENTAL BILLING INVOICES )
A MATERIAL ISSUE OF FACT OR SIMPLY AN EXAMPLE OF EXCULPATORY EVIDENCE
WHICH CAN BE EXCLUDED FROM ANY PRACTITIONERS BELLING SUMMARIES ??
THE “GOOD PERJURY” V. PLAIN OLD PERJURY EXPLANATION!
MARCH 11, 2008
ELIOT SPITZER GOES DOWN IN FLAMES IN A SEX SCANDAL AND RESIGNS AS GOVERNOR OF NEW YORK STATE

PETTIFOGGING
TWO YEARS ARE WASTED WITH THE GOVERNMENT FILING SUMMARY JUDGMENT MOTIONS

THE GOVERNMENT “EXPERT” WITNESSES
LINDA DELECA: DENTIST NOT AN INUNDED PROVIDER PAID SPOKESPERSON FOR AG DOES NOT KNOW ANY CODES WORKED 3 HOURS IN OFFICE
JOSE CASTILLO: AUDITOR NOT A CPA NOT A STATISTICIAN PRIOR JOB – READ WAITER
JOIN FISTO PROSECUTOR PEDESTRIANISM OF ARROGANCE, LAZINESS & INCOMPETENCE

THE FEDERAL CIVIL RIGHTS TRIAL
AUDITOR TESTIFIES DOCUMENTS WERE CREATED DURING THE INVESTIGATION
VERDICT SHEET: SPECIAL INTERROGATORY
JURY SENDS JUDGE A QUESTION
FINAL JURY VERDICT
SECOND CIRCUIT COURT OF APPEALS:

OMISSION OF TOOTH NUMBERS WAS "UNAVOIDABLE"

ASK FOR QUALIFIED IMMUNITY

PLEAD GENERAL VERDICT RULE

THE GOVERNMENT'S 2ND CIRCUIT COURT OF APPEALS MOTION:

TOOTH NUMBERS ARE EXCULATORY EVIDENCE AND NOT A MATERIAL ISSUE OF FACT. THERE IS NO CONSTITUTIONAL REQUIREMENT NOR OBLIGATION THAT THEY BE INCLUDED IN ANY SUMMARY OF DATA PRESENTED TO A GRAND JURY.

IF DR. MORSE PROVIDING IN THIS CASE PROSECUTORS IN AMERICA WILL NO LONGER BE ABLE TO PURSUE WHITE-COLLAR AND FINANCIAL FRAUD CRIMES !!!

THE THREE KEY THINGS YOU NEED TO DEFEND YOURSELF:

RECORDS

RECORDS

RECORDS

THE WISDOM OF PERICLES

(495-429 BC)

JUST BECAUSE YOU DO NOT TAKE AN INTEREST IN POLITICS DOESN'T MEAN POLITICS WON'T TAKE AN INTEREST IN YOU !!!
Policy Limits, Payouts, and Blood Money: Med Mal Settlements in the Shadow of Insurance

Charles Silver, David A. Hyman, Bernard Black & Myungho Paik

Insurers Want You To Think You Face Significant Personal Exposure

Are Doctors Just One Malpractice Claim Away From Bankruptcy?

If You’re An Insured Physician In TX, Your Personal Exposure Is Small

- 77 claims with OOPPs, totaling $15.9M over 18 years.
  - Likelihood per physician per year: 0.015%
  - $ per physician per year: $30
- Mean (median) OOPP per claim: $206K ($62K).
  
Source: Texas Physician Closed Claims, 1988-2005

Out of Pocket Payments: Actual and by Policy Limits

Payments Stack Up At The Policy Limits

Mean Real Policy Limits By Purchase Year

Nominal Policy Limits By Purchase Year

Few OOPPS: “Blood Money” Norms or Basic Economics?

TX docs have reduced their personal exposure to near zero.
- The remaining exposure appears to reflect a rational calculation that the added cost of a larger policy exceeds the added value.
- Why don’t plaintiffs’ attorneys pursue personal assets more often?
  - Economics 101: Opportunity cost of pursuing personal assets when policy limits are on the table exceeds the expected gain.

Deterrent Impact of Tort Law

Physicians have deficient incentives to protect patients from avoidable mistakes.
- The deterrent effect of med mal liability is mediated by insurers.
  - Insurers do more than people think.
    - Risk-rated insurance premiums and underwriting.
    - Annual reviews upon renewal.
    - Required training and procedure compliance by physicians.
    - Discouraging part-time practice.
  - Insurers’ incentives are also deficient.

Policy Limits Deserve More Attention

- Real policy limits have shrunk dramatically over time.
- Other changes (tort reforms, subrogation, etc.) have made med mal lawsuits less profitable.
  - Secular decline in med mal litigation.
- Financial responsibility is shifting/has shifted from providers and their insurers to patients, their insurers, and their families.
CYRIL WECHT LUNCHEON

This lecture made possible through a grant from the ACLM Foundation

SATURDAY, FEBRUARY 27, NOON - 1:15PM

Wedgwood Ballroom

MODERATOR:
Cyril H. Wecht, MD, JD, FCLM

PRESENTER:
Richard Adler, MD, Forensic & Clinical Psychiatry
CYRIL WECHT LUNCHEON
HONORARY LECTURE
ACLM ANNUAL MEETING 2016
FEBRUARY 27, 2016
AUSTIN, TEXAS
RENAISSANCE AUSTIN HOTEL
12:00 PM – 1:15 PM

RICHARD S. ADLER, M.D.
FORENSIC & CLINICAL PSYCHIATRY
SEATTLE, WA

FORENSIC TYPOLOGIES:
COALS TO NEWCASTLE
OR DIAMONDS IN THE ROUGH?
IN COLD BLOOD,
“THE BAREFOOT BANDIT,”
AND OTHER ILLUSTRATIVE
HIGH-PROFILE CASES
PROBABLE CAUSE

A matter of “first impressions”

“A reasonable ground for belief in certain alleged facts. A set of probabilities grounded in the factual and practical considerations which govern the decisions of reasonable and prudent persons and is more than mere suspicion but less than the quantum of evidence required for conviction.”


“A reasonable ground for belief in certain alleged facts. A set of probabilities grounded in the factual and practical considerations which govern the decisions of reasonable and prudent persons and is more than mere suspicion but less than the quantum of evidence required for conviction.”

“A reasonable ground for belief in certain alleged facts. A set of probabilities grounded in the factual and practical considerations which govern the decisions of reasonable and prudent persons and is more than mere suspicion but less than the quantum of evidence required for conviction.”


PROBABLE CAUSE

- A matter of “first impressions,”
- Theory of the crime typically not revised as the case moves towards trial,
- Confirmatory bias,
- The Reid Method,
- Do the facts of the specific case fit the usual pattern?

CONVICTION RATES IN STATE COURT

59 – 84%

Burden of Proof
Beyond Reasonable Doubt
Unanimous Death Sentence Verdict

USUAL NARRATIVE
Defendant is Evil
Defendant Made “Bad Choices”
Defendant Not Capable of Rehabilitation
Defendant is An Ongoing Risk of Danger to Others

FORENSIC CRIMINAL TYPOLOGIES
- Typologies are descriptions of the characteristic features of crimes within a given category – e.g. parricide, kidnapping
- It is the “textbook case” for a crime type

FORENSIC CRIMINAL TYPOLOGIES
Real world application of the Scientific Method Testing of the “Null Hypothesis”
Employs “Occam’s Razor”
Uses data derived from real world observation and the classifications that result from this
FORENSIC CRIMINAL TYPOLOGIES

Aspires to being atheoretical
A “big tent” which makes use of Criminology – Psychology – Psychiatry – Sociology

COLLABORATIVE

What the Crime Type Tells Us

1. How the crime is typically committed
2. What is the motive
3. Who commits such crimes
4. Who are the usual victims
5. What are the typical legal outcomes

IS FORENSIC CRIMINAL TYPLOGIES JUST ANOTHER TERM FOR PROFILING?

EXAMPLE #1

FACTS:
- Four family members are found dead.
- They were bound, gagged, and each shot once in the head at close range.
- No one was blindfolded, no masks were worn.
- The father/husband had his throat slashed superficially and before anyone else was harmed.
- The home itself was relatively undisturbed.
- Only a small radio and a pair of binoculars were missing.

STATE’S THEORY OF THE CRIME:
NIGHTTIME HOME INVASION ROBBERY “GONE BAD”
THE TYPOLOGY OF NIGHTTIME HOME INVASION ROBBERY

DEFINITIONAL ELEMENT
Motive Pecuniary Violent
Types Professional Addicts/Alcoholics
Opportunistic
Planning Less than 2 hours before
Location Urban
Injury When unarmed
Other details Familiar to victims
Blindfolded
Ruse or Disguise used
Sexually thrilling
Within 1 – 2 miles of home
Later home invasion robberies

<table>
<thead>
<tr>
<th>MEANINGFUL FEATURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motive</td>
</tr>
<tr>
<td>Types</td>
</tr>
<tr>
<td>Planning</td>
</tr>
<tr>
<td>Location</td>
</tr>
<tr>
<td>Injury</td>
</tr>
<tr>
<td>Other details</td>
</tr>
<tr>
<td>Sexually thrilling</td>
</tr>
<tr>
<td>Distance</td>
</tr>
<tr>
<td>Subsequent home invasion robberies</td>
</tr>
</tbody>
</table>
DEFINITIONAL ELEMENT CLUTTER MURDERS

Motive
Pecuniary
No

Types
Professional
Yes

Addicts/Alcoholics
No

Opportunists
No

Planning
Less than 2 hours before
No

Location
Urban
No

Injury
When unarmed
No - armed

Other details
Familiar to victim
No

Blindfolded
No

Ruse or Disguise used
No

Sexually thrilling
No

Within 1 – 2 miles of home
No

Later home invasion robberies
No

What do we know…

RSA: How typical/atypical is it to see murders like this in a nighttime home invasion robbery?

CW: It is atypical. I’ve seen brutal murders, robberies – quite a mess. I am surprised by the absence of injuries. I am surprised that a 16 year-old girl is not raped. Tells you something too. The binding of these people – planned operation, goes beyond just a rich farmer, we are going to break into his house. Clearly execution-type injuries. This is mafia-type execution wounds. Suggests organized crime killers. The work of people who have done this before. To convey a message, if you will.
EXAMPLE #2
FIVE STOLEN PLANES

STATE’S THEORY OF THE CRIME:
NO COHESIVE THEORY

FACTS:
• An 18 year-old elopes from a juvenile halfway house
• Eludes local, state and federal authorities for two years
• Commits 170 crimes across 17 states, 3 countries
• Is apprehended with a gun in his possession

Sentenced to 9.5 years, mostly in state prison.

“THE BAREFOOT BANDIT”
AKA COLTON HARRIS MOORE
DEFENSE EXPERT

LEAD COUNSEL

EXAMPLE #3
TEXAS V. GABRIEL HALL

STATE ASSERTS NO REAL MENTAL ILLNESS
NO PRIOR CRIMES
PICKS OUT A HOUSE TWO YEARS BEFORE KILLS COMPLETE STRANGERS

EXAMPLE #4
MAN IN COLLEGE’S WOMEN’S BATHROOM WEARING SHOCKING PINK WIG
PRACTICAL ISSUES
BREAKOUT SESSION IV
TERMINALLY ILL PATIENTS AND IMMIGRANTS

SATURDAY, FEBRUARY 27, 1:30PM - 3:15PM

Grand Ballroom A

MODERATOR:
John Conomy, MD, JD, FCLM
Expanded Access

Expanded Access and Expedited Approval Programs for Biomedical Products: A Global Perspective
Dr. Jack Snyder
American College of Legal Medicine
February 27, 2016

Expanded Access = Early Access = Compassionate Use

• Program regulated by FDA
  – To improve access to investigational drugs for Rx of patients with a serious or immediately life-threatening disease or condition who do not have comparable or satisfactory alternative therapeutic options and who may benefit from such therapies
• Intent is treatment of patients with most to gain & least to lose
  – Differs from use of an investigational drug in a clinical trial where primary purpose is research (i.e., systematic collection of data)
• Method of obtaining access
  – FDA approval of an Expanded Access Submission, which is a type of Investigational New Drug (IND) application (i.e., a new IND or protocol amendment to existing IND)
  – Nearly 6000 applications in last 4 years
• Mfr decides whether or not a patient can participate in a "compassionate use" trial!

Subpart I of 21 C.F.R. Part 312

• General standards AND specific standards based on the size of population and seriousness of the disease
• Requirements for obtaining access
• Safeguards, including IRB review, informed consent, and reporting requirements to FDA

Key Features of the Amended Regulations

21 CFR 312.300

• Immediately Life-Threatening Disease or Condition = "A stage of disease in which there is a reasonable likelihood that death will occur within a matter of months or in which premature death is likely without early treatment."
• Serious Disease or Condition = "A disease or condition associated with morbidity that has substantial impact on day-to-day functioning. Short-lived and self-limiting morbidity will usually not be sufficient, but the morbidity need not be irreversible, provided it is persistent or recurrent. Whether a disease of condition is serious is a matter of clinical judgment, based on its impact on such factors as survival, day-to-day functioning, or the likelihood that the disease, if left untreated, will progress from a less severe condition to a more serious one."

General Requirements
(21 CFR 312.305)

• FDA must determine that:
  – Patients to be treated have a serious or immediately life-threatening illness or condition
  – No comparable or satisfactory alternative therapy exists
  – Potential patient benefit justifies the potential risks of the treatment, and those risks are not unreasonable in the context of the disease or condition being treated
  – Providing the drug will not interfere with or compromise clinical investigations that could support marketing approval for the Expanded Access indication

Immediate Life-Threatening
Disease or Condition
Serious Disease or Condition

Immediate Life-Threatening
Emergency Use

Serious Disease or Condition
Non-Emergency Use

Immediate Life-Threatening
Large Patient Population

Serious Disease or Condition
Intermediate Size Patient Population

Non-Emergency Use

Emergency Use

Intermediate Size Patient Population

Non-Emergency Use

Large Patient Population

Immediate Life-Threatening
Emergency Use

Serious Disease or Condition
Non-Emergency Use

Immediate Life-Threatening
Intermediate Size Protocol

Serious Disease or Condition
Intermediate Size Protocol

Immediate Life-Threatening
Treatment Protocol

Serious Disease or Condition
Treatment Protocol

Immediate Life-Threatening
Single Patient Emergency IND

Serious Disease or Condition
Single Patient IND

Immediate Life-Threatening
Single Patient Emergency Protocol

Serious Disease or Condition
Single Patient Protocol

Immediate Life-Threatening
Intermediate Size IND

Serious Disease or Condition
Intermediate Size Protocol

Immediate Life-Threatening
Treatment IND

Serious Disease or Condition
Treatment Protocol

Immediate Life-Threatening
Single Patient Emergency

Serious Disease or Condition
Single Patient

Immediate Life-Threatening

Serious Disease or Condition

Immediate Life-Threatening
Large Patient Population

Serious Disease or Condition
Intermediate Size Patient Population

Immediate Life-Threatening
Non-Emergency Use

Serious Disease or Condition
Non-Emergency Use

Immediate Life-Threatening

Serious Disease or Condition

Immediate Life-Threatening

Serious Disease or Condition
Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Emergency Use

Immediate Life-Threatening

Can Manufacturer Charge for Investigational Drug Under Expanded Access Program?

- **YES**, under 21 CFR 312.8, mfr must request authorization from FDA and demonstrate:
  - Sufficient enrollment in any ongoing clinical trial needed for marketing approval to assure FDA that it will be successfully completed as planned;
  - Evidence of adequate progress in drug development for marketing approval;
  - Information specifying drug development milestones the sponsor plans to meet in next year; and
  - Amount to be charged recovers only direct costs of manufacturing, shipping, and handling; for Expanded Access, may also charge for costs of monitoring, complying with FDA reporting requirements, and other administrative costs.
- If company is not the sponsor of the Expanded Access IND, it is not required to obtain authorization from FDA to charge for the investigational drug.

Can Manufacturer Charge for Investigational Drug Under Expanded Access Program?

- **YES**, if mfr meets 4-part test:
  - Drug must exhibit evidence of clinical benefit;
  - Data from trial is essential to obtaining future approval for it;
  - Trial could not be conducted without charging;
  - Amount being charged is reasonable

Expanded Access Requests Accepted by FDA

<table>
<thead>
<tr>
<th>Request Type</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expanded Access IND</td>
<td>1,066</td>
<td>313</td>
<td>287</td>
<td>442</td>
<td>500</td>
</tr>
<tr>
<td>Single Patient IND</td>
<td>692</td>
<td>550</td>
<td>496</td>
<td>652</td>
<td>484</td>
</tr>
<tr>
<td>Intermediate Size IND</td>
<td>50</td>
<td>27</td>
<td>14</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Treatment IND</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1,808</td>
<td>890</td>
<td>797</td>
<td>1,094</td>
<td>986</td>
</tr>
</tbody>
</table>

Expanded Access Requests Rejected by FDA (0.5% of all apps)

<table>
<thead>
<tr>
<th>Request Type</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expanded Access IND</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Single Patient IND</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Intermediate Size IND</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Treatment IND</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>16</td>
</tr>
</tbody>
</table>

Expanded Access at FDA (FY 2010-2014)

Physician Views on Compassionate Use

Should compassionate use be allowed for unproven drugs or therapies?

- Yes, but only if the patient has no other options: **74%**
- Yes, clinical trials take too long: **19%**
- No, it’s unethical to do so: **7%**

SERMO Physician Poll • Feb 2013 • 1,182 Votes • blog.sermo.com
**Principles of Expanded Access (Brookings)**

**FDA Form 3926**
- Physician must submit 8 pieces of information:
  - Patient's initials
  - Clinical indication, history, rationale for request
  - Drug name and Rx plan
  - Letter of authorization from mfr
  - Physician qualification statement
  - Physician contact information
  - Formal request for authorization
  - Certification statement — no RX for at least 30d after FDA receipt of application, also ICF, IRB, IRB within 5d of emergency

**Multiple Expanded Access Emergency Uses of Same Drug at Same Institution**
- “Once an investigational drug is used in an emergency situation without prior IRB approval, any subsequent uses of the investigational drug at that same institution would ordinarily require prior IRB review and approval…” but FDA will not deny further emergency access if prior IRB review is not feasible. Draft Guidance, Q11

**Medicare Coverage in Expanded Access Programs**
- Medicare coverage policies do not specifically address the situation where unapproved/investigational drugs are used for treatment purposes
- Two paradigms:
  - (1) “Reasonable and Necessary” Standard
  - (2) Clinical Trial Policy (NCD)
- Under either paradigm, the investigational drug itself is usually not covered, but other items and services associated with clinical care and/or treatment of the patient are likely covered. Examples include:
  - Costs of infusion of an investigational drug and overnight observation services to monitor the patient
  - Costs of hospital stay to monitor/treat cardiac complications resulting from use of the investigational drug
  - Costs of follow-up visits to physician office for examination of potential side effects from investigational drug regimen

**Medicare Coverage in Expanded Access Programs**
- Look to Medicare clinical trial policies to determine likely Medicare coverage of Expanded Access Programs—consult your Medicare Coverage Analysis document prepared for the clinical trial
- Investigational drugs used in Expanded Access Programs are typically not covered by Medicare, so providers/patients may be responsible for costs, depending on whether a manufacturer charges for the investigational drug
- Other treatment costs associated with the use of investigational drugs in Expanded Access Programs are typically covered by Medicare, including investigational drug administration costs, diagnosis/treatment of complications, monitoring of side effects
- Items/services performed solely for data collection or analysis, provided free of charge, or not ordinarily covered by Medicare are typically not covered by Medicare in Expanded Access Programs
- "Coverage with Evidence Development“ — evolving concept for devices

**Expanded Access Issues for Physicians**
- Emergency requests
- Want access outside the program
- Want full indemnities
- Want promises of no cost to patients
- Want funding
- Locations; number of sites
- Qualified in this role?
- Not properly fulfilling investigator role
- Don’t want program to end
- Pros/cons of company-sponsored submissions
Expanded Access Issues for Manufacturers

- Supply chain
- How to say "No"
- Other stakeholders
- Distraction from clinical trials/application
- Transparency and Availability of Process Information
- Updating of information
- Monitoring and other efforts/burden/costs
- Letting product out of tightly controlled environments
- Remove incentive to enroll in clinical trials
- Liability exposure?

Expanded Access Issues for FDA

- Tremendous discretion
- Evidence of safety
- Can get different decisions from FDA
- Is drug being developed for population to be treated, and if not, why not, or under what circumstances could it be?
- EAP vs. open-label safety study
- Risk of interference with clinical investigations
  - "Significant number" of similar requests can result in FDA request for more sponsor involvement
- Does EAP mean less incentive for FDA to approve?

Legal Challenges in EAP

- U.S v. Rutherford (no constitutional right to access to amygdalin (Laetrile)(1979)
- Abigail Alliance v. von Eschenbach (2007)(no fundamental right...to experimental drugs for terminally ill)
- Contract right of access if received drug during clinical trial? (but investigator promises don’t bind a manufacturer)

State “Right-to-Try” Laws

- CO, LA, MI, AZ, MO versions – right to “mitigate extreme suffering and to enhance self-preservation” supported by different risk-benefit thresholds among individuals
- Constitutionality suspect if conflict with FDA enabling legislation and EAP regulations (preemption doctrines)
- Inadequate data = inadequate risk assessment?
- Inadequate data = inadequate informed consent?

Pearls to Remember

- “Compassionate Use” – a potentially misleading term
- Manufacturer is not required to provide investigational drug or provide it free of charge
- Physician always incurs regulatory obligations as investigator, including obligations as sponsor-investigator, if the physician is holder of the Individual Patient IND
- Potential medical costs may be incurred by the patient, including costs of the drug and medical expenses for injury
- Use of drug at stage of early and incomplete understanding of its safety risks means possible overestimation of benefit and underestimation of risk

Possible Paths Forward for EAPs

- FDA attempts to shorten interval between “determination of clinical utility” and “point of wide availability”
- FDA-State collaboration
  - Fund specialized IRBs
  - Mfr places profits in interest-bearing escrow until drug is “approved”
Resources on Expanded Access


Resources on Expanded Access

- http://www.fda.gov/NewsEvents/PublicHealthFocus/ExpandedAccessCompassionateUse/default.htm?utm_source=FDA.Facebook
- http://www.fda.gov/forconsumers/byaudience/forpatientadvocates/accessoinvestigationaldrugs/default.htm
- http://www.fda.gov/ForConsumers/ByAudience/ForPatientAdvocates/AccesstoInvestigationalDrugs/ucm176098.htm

Resources on Expanded Access


Resources on Expanded Access


Compare EMA and FDA

- Expanded Access ≠ Expedited Approval
Who’s Faster: EMA or FDA?

Comparison of Licensing Flexibilities

**EMA**
- Approval under exceptional circumstances
- Applicants must demonstrate that they are unable to provide comprehensive data on the efficacy and safety under normal conditions of use (e.g. rare conditions)

**FDA**
- No direct equivalent procedure

---

Comparison of Licensing Flexibilities

**EMA**
- Similar supportive mechanisms to fast track designation
- Innovation task force/SME office/CHMP scientific advice & protocol assistance/Qualification of novel methodologies for medicine development
- Facilitate development and expedite review of drugs through more frequent FDA interaction and rolling review of data

**FDA**
- Fast track designation

---

Comparison of Licensing Flexibilities

**EMA**
- Conditional Approval
- Allows approval of a drug for serious or life threatening conditions based on less complete data than is normally required, subject to certain specific obligations to be reviewed annually

**FDA**
- Accelerated approval
- Allows approval of a drug for serious or life threatening conditions based on an effect observed on a surrogate endpoint that is reasonably likely to predict clinical benefit

---

Comparison of Licensing Flexibilities

**EMA**
- Accelerated assessment
- CHMP opinion given within 150 days as opposed to 210 days

**FDA**
- Priority review
- Regulatory review period shortened from standard 10 months to 6 months

---

Comparison of Licensing Flexibilities

**EMA**
- Similar supportive mechanisms to breakthrough designation
- Innovation task force/SME office/CHMP scientific advice & protocol assistance/Qualification of novel methodologies for medicine development

**FDA**
- Breakthrough designation
- Expedite the development and review of drugs through more intensive FDA guidance and commitment to involve senior management
Comparison of Licensing Flexibilities

**EMA**
- Orphan Designation
- A supportive legislative framework for medicines for rare diseases was adopted in Europe in 2000 (Regulation (EC) 141/2000). Although similarities exist, the criteria and processes for designation are not internationally harmonised. However, a common joint EMA/FDA orphan designation application form is available.

**FDA**
- Orphan Designation
- A supportive legislative framework for medicines for rare diseases was adopted in the USA in 1983 (the Orphan Drug Act).

---

**Expert Opinion on Orphan Drugs, 1:7, 507-510 (2013)**

- Since the 1980s, FDA has expedited drug development using a number of programs.
- In 2012, the Food and Drug Administration Safety and Innovation Act created a new program, Breakthrough Therapy designation, for drugs intended to treat a serious condition that preliminary clinical evidence indicates that the drug may demonstrate substantial improvement over available therapies.
- All of these expedited programs are available to all drugs intended to treat serious conditions, it is in the area of rare diseases where these programs have the greatest potential to favorably affect new drug development.
- Speed and precision in developing the clinical evidence needed to support regulatory approval are not mutually exclusive goals.
- Demonstration of comprehensive scientific evidence of product quality, effectiveness, and safety and careful assessment of this evidence by FDA remain the most important determinants for application approvals.

---

**"Guidance for Industry: Expedited Programs for Serious Conditions-Drugs and Biologics" (May 2014)**

---

**Australia**

Comparison of Expedited Processes at FDA

EMA Adaptive Licensing for Orphan Drugs (Fast Track Market Access)
- Pilot as of March 2015 to explore AL for conditions with unmet medical need
- Progressive licensing approach with meds in early-stage development
- Goal is to refine AL pathways for compatibility with a range of products

Early Access to Medicine Scheme (EAMS)
- Initiated April 7, 2014 by MHRA (UK)
- Designation as “promising innovative medicine” (PIM)
- Analyze data from clinical trials
- Issue benefit/risk opinion on whether product should be used before license is approved
- Renewable opinion good for ONE year or until MA granted
- Public Assessment Reports (PARs)
**MHRA – PIM Designation Statistics**

<table>
<thead>
<tr>
<th>EAMS step I PIM designations - April 2014 to November 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications received</td>
</tr>
<tr>
<td>PIM designations granted</td>
</tr>
<tr>
<td>PIM designations refused</td>
</tr>
<tr>
<td>PIM designations pending</td>
</tr>
</tbody>
</table>

**MHRA – Scientific Opinion Statistics**

<table>
<thead>
<tr>
<th>EAMS step II applications - April 2014 to December 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications received</td>
</tr>
<tr>
<td>Opinions awarded</td>
</tr>
<tr>
<td>Opinions refused</td>
</tr>
<tr>
<td>Opinions pending</td>
</tr>
</tbody>
</table>

**Criteria of an EAMS Application**

- (a) Life threatening or seriously debilitating condition and (b) High unmet need, i.e., there is no methods available or existing methods have serious limitations
- Medicinal product is likely to offer significant advantage over methods currently used in the UK
- Potential adverse effects of the medicinal product are considered to be outweighed by the benefits, allowing for the reasonable expectation of a positive benefit/risk balance
- Applicant is able to supply the product and to manufacture it to a consistent quality standard (GMP)

**EAMS Timeline Options**

**Comparison of Breakthrough therapy designation and MHRA processes**

**FDA**
- Holding meetings with the sponsor and the review team throughout the development of the drug.

**MHRA**
- The MHRA offers a scientific advice service in face to face meetings, which can be requested during any stage of the development of a medicinal product.

**Comparison of Breakthrough therapy designation and MHRA processes**

**FDA**
- Providing timely advice to, and interactive communication with, the sponsor regarding the development of the drug to ensure that the development program to gather the nonclinical and clinical data necessary for approval is as efficient as practicable.

**MHRA**
- Following a scientific advice meeting, a final scientific advice letter is sent to the company within 30 working days of the meeting. The MHRA has launched an ‘Innovation Office’, aimed at providing regulatory advice and to support research and development. The EU system also provides extensive guidance to applicants outlining requirements.
### Comparison of Breakthrough therapy designation and MHRA processes

**FDA**
- Taking steps to ensure that the design of the clinical trials is as efficient as practicable, when scientifically appropriate, such as by minimizing the number of patients exposed to a potentially less efficacious treatment.

**MHRA**
- National scientific advice covers aspects such as endpoints, trial duration, target population, choice of comparator and statistical methodology. EMA scientific advice provides similar advice. The MHRA’s dedicated clinical trial unit carries out timely approval of clinical trial applications, 100% within statutory timelines. The MHRA has strong expert representation on European committees including Committee on Human Medicinal Products (CHMP) and Scientific Advice Working Party (SAWP).

### Orphan Designation

- 21st Century Cures Act
- Right-to-Try Laws
- FDA Guidance
- EAP Task Force
- Program Planning and Design
- Supply Equity
- Product Forecasting
- Stakeholder Collaboration
- Global Request Management
- Country-Specific Regulations
- EAP Partnerships
- Outsourcing Strategies
- Reimbursement Models
- Benefits/Risk Assessment
- Real-World Data
- Patient Reported Outcomes
- EAP Close Out and Transition
- Expanded Access Programs, Early Access Programs, Compassionate Use Programs, Named Patient Programs and Managed Access Programs.
- best practices around providing investigational, pre-launch or end-of-lifecycle drugs to patients for treatment purposes

### Definitions of “Biosimilars”

- 21st Century Cures Act
- Right-to-Try Laws
- FDA Guidance
- EAP Task Force
- Program Planning and Design
- Supply Equity
- Product Forecasting
- Stakeholder Collaboration
- Global Request Management
- Country-Specific Regulations
- EAP Partnerships
- Outsourcing Strategies
- Reimbursement Models
- Benefits/Risk Assessment
- Real-World Data
- Patient Reported Outcomes
- EAP Close Out and Transition
- Expanded Access Programs, Early Access Programs, Compassionate Use Programs, Named Patient Programs and Managed Access Programs.
- best practices around providing investigational, pre-launch or end-of-lifecycle drugs to patients for treatment purposes

MEDICAL DEPORTATION: LEGAL AND ETHICAL ISSUES
Sana Loue, J.D., Ph.D., M.P.H., M.S.S.A., M.A., LISW, CST, AVT
2016 ACLM 56th Annual Meeting
February 27, 2016
Austin, Texas

IDENTIFYING MEDICAL DEPORTATION
- Medical transfer
- Medical repatriation
- Hospital deportation
- Forcible/forced repatriation
- Forcible immigrant shipping
- Medical rendition
- Private deportation
- International patient dumping
- Hospital-effectuated international expulsion
- Extrajudicial deportation
- Extralegal deportation
- Patient export

HOSPITAL-EFFECTUATED INTERNATIONAL PATIENT EXPULSION
- >800 incidents in 6 year period from 15 states to ≥7 countries
- Cost of “repatriation”: $35k-$200k (Harasim 2009)
- Often effectuated through reliance on private company, e.g. Mexcare
  - “An alternative choice for the care of the unfunded Latin American national”
  - Company website does not list facilities in Latin America with which it collaborates
  - NYT reports that the insurance offered by MexCare to encourage consent does not cover needed services, such as dialysis (Sack 2009)
  - Often no follow-up by sending healthcare facility (Sontag 2008)

UNDERSTANDING THE CONTEXT
- Emergency medical situation or serious chronic illness
- Federal requirement to provide emergency medical care to stabilize patient
- Discharge plan and transfer to appropriate facility to ensure health and safety of patient
- Patient’s lack of adequate resources or health care insurance
- Hospital’s inability to recover long-term care costs or to identify accepting facility for transfer

SCOPE OF CHALLENGE
- 33m individuals in US (10.4% of population), lack healthcare insurance (Barry-Jester & Casselman 2015)
  - Disproportionately poor, black and Hispanic
  - 4.5m are children
  - 7m are noncitizen immigrants
  - Estimated 600,000 in country ≤5 years; ineligible for publicly funded care
- Cost of providing uncompensated care to immigrants approx. $4.3b/yr; approx 10% of unreimbursed costs of care for uninsured and underinsured per American Hospital Assn (Moore 2013)
- 2007: California Medi-Cal spent $20m on 460 patients
- 2005 estimates: 75% of undocumented persons pay payroll taxes, contribute $7b to Social Security Administration and $1.5b to Medicare with no possibility of receiving benefits (Porter 2005)

From Barry-Jester & Casselman 2015

The Uninsured: Immigrants

7 million of the uninsured in 2014 were noncitizen immigrants.
31% of these immigrants were uninsured vs. 8.8% of U.S. citizens.
This gap varies across groups.

From Barry-Jester & Casselman 2015

ACLM 56th Annual Meeting Program Book
HOSPITAL-EFFECTUATED INTERNATIONAL PATIENT EXPULSION:
Consequences 1.
- For hospital
  - Reduction in burden of uncompensated care
  - Use of third party may insulate hospital from liability
  - May comply with EMTALA provision requiring arrangement for implementation of discharge plan
  - Transforms hospital into self-funding travel agency (Appel 2012)
  - Blurs the boundary between provision of health care and law enforcement

HOSPITAL-EFFECTUATED INTERNATIONAL PATIENT EXPULSION:
Consequences 2.
- For patient
  - Potential loss of immigration status, ineligibility for U.S. citizenship, or imposition of bar to re-enter the U.S.
  - Potentially inadequate care
  - Separation from U.S.-based family members
  - Legal costs
- For community
  - Distrust of health care providers (Moran 2009)
  - Possible upswing in untreated communicable disease

LEGAL AND ETHICAL ISSUES
- Constitutional issues
  - U.S. Constitution, Art. I, Sec. 8: Grants to Congress the power: “To establish a uniform rule of naturalization”
- Statutory issues:
  - Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)
  - Emergency Medical Treatment and Active Labor Act (EMTALA)
- Tort issues:
  - Absence of informed consent
  - Medical malpractice
  - False imprisonment
  - Emotional distress
- Quality of care; access to care
- Healthcare provider conflict of interest

CONSTITUTIONAL ISSUES
- U.S. Constitution, Art. I, Sec. 8: Grants to Congress the power: “To establish a uniform rule of naturalization”
- Montejo v. Martin Memorial Hospital, 874 So. 2d 654 (Fla. App. 2004)
  - Federal law preempts state power to deport persons within its borders
  - Circuit court judge did not have subject matter jurisdiction to authorize deportation

PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT (PRWORA)
- Legal immigrants who entered US after 8/22/1996 ineligible for public benefits during first 5 yrs in US; for those with affidavit of support, possibly 10 years
- Bar includes Medicaid, Medicare, State Children’s Health Insurance Programs
- Exceptions for emergency medical care, immunizable diseases, tx for six of communicable diseases
- Limits post-stabilization healthcare funding
- Coverage available to undocumented immigrants for post-emergency care—NYC, California
  - As of 2006, 22 states and DC extended some Medicaid coverage to undocumented immigrants (Kaiser Commission, 2006)

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)
- Established in 1986; known as “anti-patient dumping statute”
- Requires that hospitals participating in Medicare program that maintain ED provide for appropriate medical screening to determine existence of emergency medical condition
  - Appropriate if hospital screens indigent pt in same manner as it would paying pt (Cleland v. Bronson Health Care Group, 917 F.2d 266 6th Cir. 1990)
- Requires stabilization of emergency medical condition prior to transfer or discharge to an appropriate medical facility
INFORMED CONSENT

- Legal and ethical requirement
- Professional standard
  - What a reasonable physician would find necessary to disclose to a patient based on the circumstances
- Reasonable patient standard
  - What a reasonable patient would want to know about the medical procedure, its risks and benefits

MEDICAL MALPRACTICE

- Unlikely to succeed (Procaccini 2010)
- Physician or hospital has duty to exercise the same degree of care as "a physician in good standing in the same medical specialty on a similar community in like circumstances" (Webb 2001)
- Standard of care shifts as professional consensus shifts
- Has repatriation become a customary and accepted medical practice?

FALSE IMPRISONMENT 1.

- Montejo v. Martin Memorial Medical Center, 874 So. 2d 654 (Fl. Dist. Ct. App. 2004)
  - Guardian appealed from circuit court order allowing hospital to repatriate decedent's, an uninsured immigrant to Guatemala.
  - Fla Ct of Appeals found "there was no competent substantial evidence to support Jimenez's discharge from the hospital."
  - Ct held hospital was not an agent of govt executing court order and was not entitled to qualified immunity or quasi-judicial immunity; remanded

FALSE IMPRISONMENT 2.

- Cruz v. Central Iowa Hospital Corporation, 826 N.W.2d 516 (Iowa Ct. App. 2012)
  - 2 undocumented men from Mexico, hit by truck, required long-term care
  - Hospital had them transported to Vera Cruz, Mexico while semi-comatose
  - Filed suit for false imprisonment
  - Court found consent due to families' lack of "vehement objection"
  - Court rejected plaintiffs' claim f harm, finding that it was not the hospital's fault that the men received poor medical care
  - Court found no emotional harm because they only learned of their confinement when they awoke in Mexico

IS THE PRACTICE ETHICAL

- In limited circumstances
  - Transfer seen by a reasonable person as being in pt best interests, apart from payment issue
  - Hospital exercises due diligence regarding medical support available at intended destination
  - Patient or appropriate surrogate has provided fully informed consent to have pt returned (Kuczewski 2012)

ACCESS TO CARE; QUALITY OF CARE

- Legal and ethical issue: Can a facility in a foreign country that does not meet the US standard of care for a specific condition be an appropriate facility even assuming that facility provides the best care available in that country?
- Issue of distributive justice at individual and societal levels:
  - "The indigent patient should receive equal care and be treated with the same respect and thoughtful concern as the patient who can pay for it" (Am College of Physicians Ethics Manual 1996)
  - "A physician must advocate for his or her patient even if the hospital administration has debts or is near bankruptcy" (Greenough 2009)
  - Does society owe obligation to those who have paid into system, contributed through labor?
PROVIDER CONFLICT OF INTEREST

- Position, salary dependent on employer
  - relatively few physicians remain in nonaffiliated practice
- AMA Principles of Medical Ethics, rev. 6/2001:
  - preamble: As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self.
  - iii. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
  - ix. A physician shall support access to medical care for all people

PROPOSED REMEDIES 1.

- Incorporate jurisdiction over medical repatriation cases into Executive Office for Immigration Review (Irshad 2012; see also Bresa 2010)
- Entertain individuals’ application for asylum status (Oakley & Sorell 2012; Stead 2010)
- Effectuate repatriation through DHS/ICE following hospital notification (Irshad 2011)
- Repeal bars to medical coverage for (un)documented immigrants (Oakley & Sorell 2012; Stead 2010)
- Institute federal requirement that nursing homes/long-term care facilities accept undocumented patients (Bresa 2010)

PROPOSED REMEDIES 2.

- Federal ban on forced repatriation (Smith 2010)
- Claim pursuant to Racketeer Influenced and Corrupt Organizations Act (RICO) (Smith 2010)
- Actions under 42 USC 1983 against employees of public hospitals as state actors
  - conduct under color of state law
  - violation of rights under federal law or US constitution (Ponce 2010; Vonnk 2010)
  - but see Monticello v. Martin Memorial Medical Ctr (CO court held hospital was not an agent of govt executing court order and was not entitled to qualified immunity or quasi-judicial immunity)
- Court review of informed consent provisions and agreement (Cantwell 2012)
  - informed consent to specify immigration consequences of repatriation and of refusal, e.g., hospital report to ICE
  - Review-transfer agreement for procedural and substantive unconscionability

PROPOSED FRAMEWORKS FOR ETHICAL ANALYSIS

- Ethical (Brown & Dobrin):
  - examine the date
  - think about which persons should be involved in decision
  - humanize options by constructing decision tree
  - incorporate ethical principles and legal statutes
  - choose an action
  - act
  - look back and evaluate choices
- Theory of moral reckoning (Brown & Dobrin):
  - recognize conflict in values, institutional values, code of ethics, and personal values
  - healthcare provider addresses internal conflict; make a stand or give up
  - reflect on actions

POSITION STATEMENTS

- American Medical Association Council on Ethical and Judicial Affairs, 2009
- California Medical Association House of Delegates, Resolution 105a-08: “OMA oppose[s] forced repatriation of patients”

CONCLUSIONS

- Complex issue involving access to care, and extent and quality of care for individuals and hospital need to remain solvent
- Conflicting legal obligations placed on healthcare institutions through inconsistent statutory schemes
- Healthcare institutions are not competent to determine individuals’ immigration/citizenship status
- Inadequate efforts made to amend legislation and to explore alternative solutions
- Increased outreach to immigrant groups warranted
- Additional research needed to document extent and context of occurrence
- Increased focus on education of healthcare professionals with respect to ethical and legal issues, e.g., in context of bioethics and/or cultural sensitivity
Police Shootings and Other Police-Related Deaths

Cyril H. Wecht, M.D., J.D.
Forensic Pathologist - Attorney - Medical-Legal Consultant
Past President, American College of Legal Medicine
Past President, American Academy of Forensic Sciences
cyrilwecht.com

Michael Brown (1996–2014)

Grand Jury Heard Dramatic, Conflicting Testimony

Police Shootings and Other Police-Related Deaths
February 2016
cyrilwecht.com

Michael Brown (1996–2014)

Pathological & Witness In Ferguson Death Inquiry

Police Shootings and Other Police-Related Deaths
February 2016
cyrilwecht.com


NEW YORK OFFICER WON’T BE CHARGED IN CHOKEHOLD CASE

Police Shootings and Other Police-Related Deaths
February 2016
cyrilwecht.com


Protests greet grand jury decision in N.Y.

Police Shootings and Other Police-Related Deaths
February 2016
cyrilwecht.com
Freddie C. Gray, Jr. (1990–2015)

February 2016

Police Shootings and Other Police-Related Deaths

cyrilwecht.com
The Tragedies Continue…

Trooper in Jail-Death Case Is Investigated

Moving Forward…

Complaints In Baltimore About A Law Protecting Police Officers

Moving Forward…

Restoring Faith in Justice

Moving Forward…

Police Misconduct Costs Soar

Moving Forward…

Group Raises Alarm About FBI ‘abuses’

Justice Dept., FBI to Review Use of Forensic Evidence in Thousands of Cases

The Washington Post

Los Angeles Times

ACLM 56th Annual Meeting Program Book
Moving Forward…

A System, With Exceptions, That Favors Police in Fatalities

February 2016

Police Shootings and Other Police-Related Deaths

37

cyrilwecht.com

Moving Forward…

Though Actions of the Police End in Death, Officers Are Seldom Charged

February 2016

Police Shootings and Other Police-Related Deaths

38

cyrilwecht.com

Moving Forward…

How to Force Prosecutors to Play Fair

February 2016

Police Shootings and Other Police-Related Deaths

39

cyrilwecht.com

Moving Forward…

Ending Secrecy About the Police

February 2016

Police Shootings and Other Police-Related Deaths

40

cyrilwecht.com

Moving Forward…

The New York Times

Stop Hiding Police Misconduct

The state Legislature needs to bring New York’s disclosure laws in line with the 41 states that apply the same standard to all state employee misconduct records, including police officers. In the meantime, the courts and cities should interpret state law in a way that brings transparency to the disciplinary process.

February 2016

Police Shootings and Other Police-Related Deaths

41

cyrilwecht.com

Moving Forward…

QUIS CUSTODIET IPSOS CUSTODES

WHO WILL GUARD THE GUARDS

February 2016

Police Shootings and Other Police-Related Deaths

42

cyrilwecht.com
SANDY SANBAR LECTURE

CONFRONTING TRAUMATIC BRAIN INJURY: DEVASTATION, HOPE, AND HEALING

This lecture made possible through a grant from the ACLM Foundation

SATURDAY, FEBRUARY 27, 3:30PM - 4:45PM

Grand Ballroom A

SPEAKER:

William J. Winslade, PhD, JD, James Wade Rockwell Professor of Philosophy in Medicine, Institute for the Medical Humanities, University of Texas Medical Branch Galveston and Distinguished Visiting Professor of Law and Associate Director for Graduate Programs, University of Houston School of Law
Traumatic Brain Injury in the United States: An Epidemiologic Overview

Carl R. Summers, PhD, Brian Ivins, MS, and Karen A. Schwab, PhD

Defense and Veterans Brain Injury Center, Washington, DC

ABSTRACT

A basic description of severity and frequency is needed for planning healthcare delivery for any disease process. In the case of traumatic brain injury, severity is typically categorized into mild, moderate, and severe with information from a combination of clinical observation and self-report methodologies. Recent US civilian epidemiological findings measuring the frequency of mortality and morbidity of traumatic brain injury are presented, including demographic and etiological breakdowns of the data. Falls, motor vehicle accidents, and being struck by objects are the major etiologies of traumatic brain injury. US civilian and Army hospitalization trends are discussed and compared. Features of traumatic brain injuries from Operation Iraqi Freedom and Operation Enduring Freedom are discussed. Mt Sinai J Med 76:105–110, 2009. © 2009 Mount Sinai School of Medicine

Key Words: epidemiology, head injury, traumatic brain injury.

A Centers for Disease Control and Prevention analysis of hospital, emergency department (ED), and vital statistics databases estimated that about 1.4 million people presented for medical care for a traumatic brain injury (TBI) each year in the United States from 1995 through 2001. The analysis also found that 50,000 (3.6%) of them died from their injuries, 235,000 (17%) were hospitalized, and 1.1 million (80%) were treated and released from the ED. A separate study using data about people hospitalized with TBI estimated that at the beginning of 2005, 3.17 million people in the United States (1.1% of the total population) were living with long-term disability that resulted from TBI. The number of people with TBI who present in outpatient settings other than EDs, such as physicians’ offices, is currently unknown as is the number of those with TBI who do not seek medical attention. However, the proportions of those with TBI who seek medical attention outside the ED or who do not seek any medical attention may be sizable. A study of data obtained from the 1991 National Health Interview Survey estimated that 25% of individuals with a self-reported TBI that resulted in loss of consciousness did not seek medical attention and that 14% were evaluated in clinics or offices.

These findings reveal 2 important features of TBI. One is that it is a common injury. The other is that TBI outcomes vary greatly. They also indicate that many people who have milder forms of TBI are not identified in current databases. Studying the epidemiology of TBI is challenging for a number of reasons, including limited data sources and different methods for classifying TBI severity. However, despite these challenges, enough research has been performed about the epidemiology of TBI to identify the most common mechanisms of injury and to characterize TBI risk in various segments of the population. This article summarizes findings from epidemiological studies of TBI in the United States that provide national-level data and briefly discusses some methodological considerations that can help readers of TBI epidemiology papers understand why particular methodologies were used. A brief review of recent research findings about TBI in the US military is included.

METHODS

We searched PubMed and Medline for articles published in the last 10 years that report national-level data about the epidemiology of TBI in the...
Unresolved legal and ethical issues in research of adults with severe traumatic brain injury: Analysis of an ongoing protocol

Theresa Louise-Bender Pape, DrPH, MA, CCC-SLP/L; Nancy Oddi Jaffe, JD, MSPH; Teresa Savage, RN, PhD; Eileen Collins, RN, PhD; Deborah Warden, MD

Department of Veterans Affairs (VA), Edward Hines Jr., VA Hospital, Research Service, Hines, IL; Rehabilitation Institute of Chicago, Center for Rehabilitation Outcomes Research, and Northwestern University Medical School, Department of Physical Medicine and Rehabilitation, Office of Medical Education, Chicago, IL; Rush North Shore Medical Center, Office of Legal Affairs, Assistant General Counsel, Skokie, IL; Walter Reed Army Medical Center, Defense and Veterans Head Injury Program, Washington, DC; University of Illinois at Chicago, College of Nursing, Departments of Medical-Surgical Nursing and of Maternal-Child Nursing, Chicago, IL; Uniformed Services University of the Health Sciences, Bethesda, MD

Abstract — This paper synthesizes federal and state laws and bioethics literature with observations from an ongoing research protocol to identify, define, and clarify the unresolved legal and ethical issues regarding research involving adults with traumatic brain injury (TBI). Solutions that protect rights and minimize unnecessary impediments to valuable clinical and scientific inquiry are also illustrated using the same protocol. Research was performed at intensive care, inpatient rehabilitation, and long-term acute chronic hospitals. Our research protocol identified five areas of law impacting adults with TBI: advanced directives, healthcare surrogacy acts, probate acts, power of attorney acts, and the Health Insurance Portability and Accountability Act. The published bioethics literature and responses from local human subject institutional review boards (IRBs) suggest that some of the unresolved ethical issues in research include defining vulnerability, defining informed voluntary consent, determining competency and/or decision-making capacity, using caregivers as subjects, and conducting multisite cooperative studies. Collaboration with IRB members and administrators as well as legal and research ethic scholars developed procedures that protect rights while avoiding unnecessary impediments to research. Investigations of persons with TBI and other cognitive impairments are governed by complicated and inconsistent regulations within the Common Rule and federal and state statutes. A need for clear and consistent regulatory guidance regarding multisite studies of TBI persists. In lieu of regulatory guidance, carefully researched solutions for critical peer review are needed to guide future multisite investigations of TBI.
February 5, 2010

OP-ED CONTRIBUTOR

Will Science Take the Field?

By DEBORAH BLUM

Madison, Wis.

THE warning in The Journal of the American Medical Association is not ambiguous: “There is a very definite brain injury due to single or repeated blows on the head or jaw which cause multiple concussion hemorrhages. ... The condition can no longer be ignored by the medical profession or the public.”

The report in question concerns professional athletes, hardly surprising given the worries expressed during this week’s Super Bowl runup and Congressional hearings into long-term damage caused by football-related concussions. It methodically details the well-publicized problems — loss of coordination, cognitive deficits, uncontrollable rages — that forced the N.F.L. to issue new rules this season limiting players with head injuries from returning to the field.

But what really makes the research and its conclusions so interesting is its timing: it appeared in The Journal of the American Medical Association on Oct. 13, 1928. This raises the question — at least for me — as to why we are announcing the athlete concussion-dementia link as a new, and still somewhat debatable, issue some 80 years later.

It was only in December that the N.F.L. finally conceded publicly that concussions “can lead to long-term problems.” And even that admission was contradicted a few weeks later by one of the league’s longtime brain injury experts, Dr. Ira Casson, who told a Congressional panel that there is not enough “valid, reliable or objective scientific evidence” showing that repeated blows to the head could cause permanent brain damage.

I’d argue that Dr. Casson — and his former friends at the N.F.L. — could have saved themselves and the players a lot of trouble if they’d spent just a little time in the medical archives. That 1928 medical journal paper started a drumbeat of research into head injuries in athletes, continuing throughout the 20th century and intensifying in the last decade. The 82-year-old study, by Dr. Harrison Martland, remains frequently cited by researchers today, partly for its meticulous examination of damaged brains.

The paper is also a terrific reminder of early 20th-century medicine’s down-to-earth approach to research. Martland, the chief medical examiner in Essex County, N.J., began his research by hanging out at boxing matches. He titled the paper “Punch Drunk,” drawing on boxing cant. As he pointed out, boxing fans didn’t hesitate to malign injured boxers, derisively shouting “cuckoo” when obviously brain-damaged fighters shambled into a ring, and referring to those with dementia problems as “slug nutty.”

Martland did autopsies on more than 300 people who had died of head injuries, looking for patterns of brain damage. For his study of boxers, he talked a fight promoter into giving him a list of 23 former fighters he thought could be labeled as definitely punch drunk. Martland was able to track down only 10 of the former
Chronic Traumatic Encephalopathy in the National Football League

When Andre Waters, a hard hitting National Football League (NFL) safety from 1984 to 1995, made the front page of the New York Times on Thursday, January 18, 2007, he became the third NFL player known to have died as a result of chronic traumatic encephalopathy (CTE) attributed to the multiple concussions he experienced while playing in the NFL. Preceding the 44-year-old Andre were Mike Webster, age 50, the Hall of Fame Pittsburgh Steelers center who died homeless, and Terry Long, age 42, who, like Waters, took his own life (6, 7).

All three of these athletes were known as iron men, hard hitters who never came out of the game, continuing to play through countless injuries, including concussions. All of these athletes, as well as Ted Johnson, whose front-page story was widely circulated February 2, 2007 in the New York Times and Boston Globe, shared symptoms of sharply deteriorated cognitive function, especially recent memory loss and psychiatric symptoms such as paranoia, panic attacks, and major depression after multiple concussions experienced in the NFL.

The brains of all of these deceased athletes were examined by Bennett Omalu, M.D., a forensic pathologist at the University of Pittsburgh, and shared common features of CTE including neurofibrillary tangles, neurophil threads, and cell dropout. He likened Waters' brain to that of an "octogenarian Alzheimer's patient."

Are the findings of CTE in the brains of Webster, Long, and Waters a surprise?

Certainly the Waters finding was no surprise to Julian Bailes, M.D., medical director, and Kevin Guskiewicz, Ph.D., the Director of the Study of Retired Athletes at the University of North Carolina at Chapel Hill. Their study of retired NFL players published in this journal found that those who had sustained three or more concussions were three times more likely to experience "significant memory problems" and five times more likely to develop earlier onset of Alzheimer's disease (3). A study published this year by the same authors found a similar relationship between three or more concussions and clinical depression (4).

The NFL's own publications in this journal on concussion state that they had seen no cases of CTE in the NFL (8–10). That finding is not a surprise as the NFL study included only active players in their 20s and 30s during a short 6-year window from 1996 to 2001. Other significant limitations of the NFL studies include the following:

1) History of concussion: previous concussions either in the NFL in the years before the study began or during their playing careers in high school, college, or other levels of football were not included.

2) The population of NFL players changes from year to year: new players enter the league, older players leave the league, and we do not know the number of players who constituted the 1996 population who are still in the league in subsequent years.

3) There was difficulty collecting data on loss of consciousness; the initial data collection sheet did not ask for data regarding loss of consciousness.

4) This was a multisite study with numerous different examiners; there was no uniform method of evaluation of concussion in this study.

5) Return to play data were collected on players with initial and repeat concussion; there are many other factors that go into the decision of whether or not the player should return to play, including the importance of the player to the team; the importance of the upcoming game to the team; and pressure from owners, players, and their families, coaches, agents, and media may certainly influence the final decision on when the player returns to play.
PEARLS BEFORE SWINE

And sued the city for negligence.

Making Humpty rich.

And sitting on the wall different.

All the king's horses and all the king's men couldn't put Humpty together again.

So Humpty sued wall's engineer for malpractice.

And sued the lawyer for our legal system: Yaaaaaaay!
A Primer on the Law and Ethics of Treatment, Research, and Public Policy In the Context of Severe Traumatic Brain Injury

Stacey A. Tovino, J.D.* and William J. Winslade, Ph.D., J.D.†

From the 1976 case of Karen Ann Quinlan1 to the March 20, 2004, statement of Pope John Paul II,2 physicians, lawyers, and theologians have struggled with the legal and ethical implications of treatment and public policy decisions in the context of devastating brain injury. Recent medical

* Ms. Tovino is currently a Research Professor at the University of Houston Law Center. She received a J.D. from the University of Houston Law Center in 1997.
† Dr. Winslade is currently a Distinguished Visiting Professor of Law at the University of Houston Law Center and the James Wade Rockwell Professor of Philosophy of Medicine at the Institute for the Medical Humanities at the University of Texas Medical Branch. He received a Ph.D. in Philosophy from Northwestern University in 1967, a J.D. from the University of California at Los Angeles in 1972, and a Ph.D. in Psychoanalysis from Southern California Psychoanalytic Institute in 1984.

1. In re Quinlan, 355 A.2d 647, 671-72 (N.J. 1976) (holding that “upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen’s ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital ‘Ethics Committee’ or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen’s ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor, on the part of any participant, whether guardian, physician, hospital or others.”). The Karen Ann Quinlan case was followed by a string of well-known cases, including the case of Nancy Cruzan (Cruzan v. Dir., Mo. Dep’t of Health, 497 U.S. 261 (1990)) and, more recently, the Terri Schiavo case (Schindler v. Schiavo, 866 So. 2d 140 (Fla. Dist. Ct. App. 2004)).

2. On March 20, 2004, following a Vatican-sponsored symposium on the scientific and ethical issues raised by the persistent vegetative state, Pope John Paul II stated that health care providers are morally obliged to provide food and water to individuals in the persistent vegetative state because such patients “retain human dignity and have a right to be monitored for clinical signs of eventual recovery.” According to the Pope, denying food and water would constitute “euthanasia by omission” because “[t]he administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act. Its use, furthermore, should be considered, in principle, ordinary and proportionate, and as such morally obligatory.” See, e.g., Frank Langfitt, Pope’s Stand on Life Support Unclear for Church Hospitals: Giving Food, Water Moral Obligation, Pontiff Says, BALTMore SUN, Apr. 3, 2004, at 1A.
THE CATASTROPHE

Spalding Gray’s brain injury.

BY OLIVER SACKS

What role did the car crash and the damage to his frontal lobes play in his decline?

PHOTOGRAPH BY NOAH GREENBERG

In July of 2003, my neurological colleague Orrin Devinsky and I were consulted by Spalding Gray, the actor and writer who was famous for his brilliant autobiographical monologues, an art form he had virtually invented. He and his wife, Kathie Russo, had contacted us in regard to a complex situation that had developed after Spalding suffered a head injury, two summers earlier.

In June of 2001, they had been vacationing in Ireland to celebrate Spalding’s sixtieth birthday. One night, while they were driving on a country road, their car was hit head on by a veterinarian’s van. Kathie was at the wheel; Spalding was in the back seat, with another passenger. He was not wearing a seat belt, and his head crashed against the back of Kathie’s head. Both were knocked unconscious. (Kathie suffered some burns and bruises but no permanent harm.) When Spalding recovered consciousness, he was lying on the ground beside their wrecked car, in great pain from a broken right hip. He was taken to the local rural hospital and then, several days later, to a larger hospital, where his hip was pinned.

His face was bruised and swollen, but the doctors focussed on his hip fracture. It was not until another week went by and the swelling subsided that Kathie noticed a “dent” just above Spalding’s right eye. At this point, X-rays showed a compound fracture of the eye socket and the skull, and surgery was recommended.

Spalding and Kathie returned to New York for the surgery, and MRIs showed bone fragments pressed against his right frontal lobe, though his surgeons did not see any gross damage to this area. They removed the fragments, replaced part of his skull with titanium plates, and inserted a shunt to drain away excess fluid.

He was still in some pain from his hip fracture, and could no longer walk normally, even with a braced foot (his sciatic nerve had been injured in the accident). Yet, strangely enough, during these terrible months of surgery, immobility, and pain, Spalding seemed in surprisingly good spirits—indeed, his wife thought he was...
ANNUAL AWARDS BANQUET

PATIENTS, OUR MOST VULNERABLE POPULATION: WHERE ARE WE 15 YEARS AFTER THE INSTITUTE OF MEDICINE REPORTS ON SAFETY AND QUALITY IMPROVEMENT?

SATURDAY, FEBRUARY 27, 7:00PM - 9:00PM

Glass Oaks Ballroom

SPEAKER:

Kenneth I. Shine, MD, MACP, Special Advisor to the Chancellor, University of Texas System
PATIENTS, Our most Vulnerable Population: Where are we Fifteen Years after the IOM Reports?

Kenneth I. Shine
Dell Medical School
American College of Legal Medicine
February 25, 2016

To Err Is Human: Building A Safer Health System

First Report
Committee on Quality of Health Care in America

To Err is Human: Building a Safer Health System

- Medical errors can be defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim
- 44,000 - 98,000 people die in US hospitals each year as a result of preventable medical errors
- Errors cost $17 billion – $29 billion per year in hospitals in the US
- The majority of errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them

Key Findings

- Errors occur because of system failures
- Preventing errors means designing safer systems of care

Medical Errors

- Early recognition
- Early acknowledgement
- Prompt apology
- Early settlement

Crossing the Quality Chasm: A New Health System for the 21st Century (2001)

Described broader quality issues and defines six aims—care should be safe, effective, patient-centered, timely, efficient, and equitable—and 10 rules for care delivery redesign

2001
Studies Documenting the “Quality Gap”

- Literature review conducted by RAND
  - Over 70 studies documenting quality shortcomings

  Large gaps between the care people should receive and the care they do receive
  - true for preventive, acute and chronic
  - across all health care settings
  - all age groups and geographic areas

Major Forces Influencing Health Care

- Expanding Knowledge Base
- Information Technology
- Chronic Care Needs
- Payment Policies

Aims For Improvement

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

Ten Rules To Redesign Care

1. Care based on continuous healing relationships
2. Customization based on patient needs and values
3. Patient as source of control
4. Shared knowledge and free flow of information
5. Evidence-based decision making
6. Safety as a systems property
7. Transparency
8. Anticipation of needs
9. Continuous decrease in waste
10. Cooperation among clinicians

Information Technology

- There must be a renewed national commitment to building an information infrastructure to support health care delivery, consumer health, quality measurement and improvement, public accountability, clinical and health services research, and clinical education.
- This commitment should lead to the elimination of most handwritten clinical data by 2010
**Payment**

- Purchasers should examine their current payment methods to remove barriers that impede quality improvement, and to build in stronger incentives for quality enhancement.

- HCFA and AHRQ should identify and evaluate various options for better aligning current payment methods with quality improvement goals.

**Summary**

American health care is beset by serious problems, but they are not intractable. The committee envisions a system that uses the best knowledge, that is focused intensely on patients, and that works across health care providers and settings. Achieving this ideal will require crossing a large chasm between today’s system and the possibilities of tomorrow.

**Important Tools**

- Computerized Physician Order Entry (CPOE)
- Electronic Medical Record
- Patient Safety Indicators (AHRQ)
- Voluntary National Reporting Systems
- Proprietary Error Reporting Systems

**FDA Responses**

- Bar Codes (VA)
- 15 day reporting
- Safety Center

**Disease Management Programs**

- Improved Outcomes
- Decreased Costs
- Increasing Commercialization
- Role of Physician
- Motivation for Cost Reduction


**Keys to Success**

- Leadership
- Opinion leaders
- One-on-one instruction
- Carefully orchestrated rollout
- Local data
Administration Efforts

- Presidential Statements
- Support of Health Information Infrastructure
- Health information leadership
- CMS funding

Education Implications

- Multidisciplinary Learning
- Effective use of IT
- Continuous Quality Improvement
- Joint Problem Solving
- Team Management
- Understand the “10 Rules”

The IOM Quality Chasm Series

The IOM Quality Chasm Series

National Response

Patient Protection and Affordable Care Act: Key Quality Provisions

- Created a National Quality Strategy
- Established a Center for Quality Improvement and Patient Safety
- Established the Patient Centered Outcomes Institute (PCORI)
- Created the Center for Medicare and Medicaid Innovation
- Established a mandatory physician quality reporting program
- Requires public reporting on the quality of health insurance plans
- Requires additional reporting of patient data related to race, ethnicity, sex, and language
- Authorized numerous new payment and delivery models
Medication Errors

- Found that medication errors occurred in nearly half of all surgical procedures
- Found that one-third of all errors resulted in adverse drug events or harm to patients

Improving Diagnosis in Health Care

- nas.edu/improvingdiagnosis

The IOM Quality Chasm Series

The failure to:
(a) establish an accurate and timely explanation of the patient's health problem(s) 
or
(b) communicate that explanation to the patient

“It is likely that most of us will experience at least one diagnostic error in our lifetime, sometimes with devastating consequences.”

20th vs. 21st

- Autonomy
- Teamwork
- Solo Practice
- Systems
- Continuous Learning
- Continuous Improvement
- Blame/Shame
- Problem Solving
- Knowledge
- Change

Patient Centered Care

Well Informed Joint Patient-Doctor Decision Making

Thank you
GENERAL SESSION IV
ELDERS AND THE UNINSURED

SUNDAY, FEBRUARY 28, 8:00AM - 9:15AM

Grand Ballroom A

MODERATOR:
Alejandro Moreno, MBBS, MPH, JD, FACP
"GRANNY GOES TO JAIL": How to Avoid Medicaid Elder Care Liability in the USA

C. William Hinnant, Jr. MD JD FCLM
HINNANT MEDICAL & LAW OFFICES, LLC
Anderson, SC USA
netdoc37@aol.com
001-864-226-6132

MEDICAID AND LTC

- Established as Title IX of the 1965 Amendment to the Social Security Act
- Health insurance program for:
  - low-income families with children; aged, blind, or disabled people on SSI; low-income pregnant women and children; and people with high medical bills ("MEDICALLY-NEEDED")
- Funded & administered through state-federal partnership with States establishing eligibility standards, benefits and setting payment rates ("COMITY"). The feds pay but the states control the purse.

MEDICAID AND LTC: COVERAGE, FUNDING & DEMOGRAPHICS

- Must cover skilled nursing and home health services. MEDICARE ONLY COVERS 100 DAYS OF LTC
- Federal govt. - 57% of Medicaid funding; states 43% varies with per capita income in each state (Miss. 83%, Conn. 50%)
- 60 million (20% of US population) receive Medicaid support. 7% of the Medicaid population (4 million people) receive LTC
  - 1 million nursing home patients
  - 3 million home or community-based LTC
  - 4 million LTC BENEFICIARIES - account for 19% of all Medicaid spending (LTC is expensive)
- Medicaid Beneficiary must require skilled nursing care to qualify for LTC
  - Frez, VV, catheters, ventilation, drug changes, IV, ostomy, med monitoring, injections, diabetic care
  - May be less stringent for home or CLTC

MEDICAID AND LTC: INCOME & ASSET TESTS

- Income qualifying levels are tied to the SUPPLEMENTAL SECURITY INCOME (SSI) program (Title XVI), but limits can be higher in more liberal states. Generally $2000/$3000 Assets, $2163.00 monthly income (2014)
- In 29 states, “Medically Needy” having large medical or LTC bills, may deduct these costs to reach the required eligibility income level. Criteria are stringent as needy income level at or below SSI levels.
- Deduction may be direct or indirect by potential beneficiary paying a "co-pay" for income above qualifying level for their share of services.
- In some states, “300 percent rule” applies. There, individuals with income up to 300% of SSI ($2,163 per month in 2014), qualify for LTC
- 21 states are strict “income cap states.”

MEDICAID AND LTC: MILLER TRUSTS

- STATES MUST ALLOW PATIENTS TO QUALIFY IF EXCESS INCOME PLACED IN A “QUALIFYING INCOME OR ‘MILLER’ TRUST.” STATES ARE ABLE TO RECOVER FUNDS IN THE TRUST AFTER THE PERSON’S DEATH.
- THE MEDICALLY NEEDY OR 300 PERCENTERS MUST APPLY ALL BUT $30 TO $90 PER MONTH TOWARD THE COST OF CARE, REDUCING MEDICAID’S LIABILITY. MORE ALLOWED FOR CLTC OR HOME CARE.
- TRUST MONIES CAN COVER CLOTHING, BOOKS, TOILETRIES, BIRTHDAY FLOWERS, CABLE TV OR TELEPHONE SERVICE. ADDITIONAL ALLOWANCE FOR PAYMENT OF MEDICARE, SUPPLEMENT OR ADVANTAGE PLAN PREMIUMS.
**Medicaid and LTC: COMMUNITY SPOUSES**

- NH resident with community spouse is allowed to keep a greater proportion of income for spousal support (between $1,938.75 (majority) and $2,931 per month in 2014. Individual or couple needing Medicaid LTC must have assets less than $2,000 or $3,000, respectively.
- Community spouse can receive another allowance if medical expenses exceed a state-designated maximum. Waivers may be requested.
- Medicaid fair hearing can result in more income for the community spouse if argument supports need.

**ASSETS NOT COUNTING TOWARDS THE $2,000 ASSET LIMIT**

- Personal possessions - clothing, furniture, and jewelry
- One vehicle excluded, regardless of value - must be used for transportation of LTC spouse or household member. Value of additional vehicle can be excluded if needed for health or self-support (business) reasons. (state rules)
- Principal residence – must be in the same state in which LTC patient applying for coverage
- Prepaid burial plans and small amount of life insurance
- “Inaccessible” Assets (trust monies, etc.)
- Income producing property, or if used in trade or business

**INCOME TEST EXCLUDES:**

- Nutritional assistance such as food stamps
- Housing assistance provided by the federal government
- Home energy assistance
- Some earnings if CLIENT HAS earned income from work

ALL OTHER PASSIVE AND ACTIVE INCOME INCLUDING veterans’ BENEFITS, DIVIDENDS, interest, PENSIONS, social security and most wages apply as income

**ELDERCARE LIABILITY AND PERSONAL HOMES**

- State may require a single Medicaid LTC beneficiary not residing in a home without anticipation of return to sell it to pay for Medicaid costs.
- Other states allow the home to be vacant in anticipation of returning whether the patient is capable or not. An “Intent to Return Home” document must be executed to avoid the home’s sale or its being an asset for the Resource Test.
- For states fully implementing the Deficit Reduction Act of 2005, home equity exceeding $543,000 ($814,000 in some states) must be counted as an asset to qualify under the asset test. This rule does not apply if a comm. spouse lives in the home

**“GRANNY (OR HER LAWYER?) GOES TO JAIL”**

- HIPAA 1996 - criminal penalties (one year) and/or fine of $10,000.00 for person “knowingly and willfully disposing of assets” for the purpose of becoming Medicaid eligible
- repealed shortly after its enactment, by Sec. 4734 of the Balanced Budget Act of 1997, which freed Granny from the threat of jail.
- SLOGAN WAS USED TO PEDDL LTC POLICIES EVEN INTO THE 2000’S
- “persons who for a fee assist others in disposing of assets” to qualify for Medicaid, became known as the “Granny’s Lawyer Goes to Jail” law. Penalties for Granny’s advisors - fine not to exceed $10,000 or imprisonment for not more than a year, or both. (BBA 1997)
“GRANNY’S LAWYER GOES TO JAIL”

- Attorney General Janet Reno opined that was violative of The First Amendment in communication to Speaker Gingrich.
- New York State Bar v. Reno, 999 F. Supp. 710 (1998), held that the law put advisors in a quandary where they had a duty to obey the law but also an ethical obligation to provide clients with complete representation.
- Applied even though it was not illegal to dispose of assets for purposes of qualification for Medicaid at that time.
- Federal Court granted preliminary injunction prohibiting enforcement.

The Deficit Reduction Act of 2005 (DRA)

- In states with “filial responsibility laws,” nursing homes may seek reimbursement from residents’ children.
- The state is required to be the remainder beneficiary as to all annuities.
- Continuing Care Retirement Communities (CCRCs) may require residents to spend down resources before applying for medical assistance in the LTC (skilled nursing) area.
- Sets rules under which individual’s CCRC entrance fee is considered an available resource.

DRA: CLOSURE OF ASSET TRANSFER LOOPHOLES

- Life estate is an asset unless grantee resides in home for at least a year after origination.
- Funds to purchase note, loan or mortgage counted as asset unless repayment terms are actuarially sound, involve equal payments and prohibit cancellation at death of lender.
- States cannot “round down” fractional periods of ineligibility in determining ineligibility periods due to asset transfers.
- Multiple transfers can be treated as single with penalty period beginning on the earliest transfer date.

DRA: ADDITIONAL CONSTRAINTS ON WAIVERS

- States not required to offer spousal poverty protections to home and CLTC waiver program participants.
- 19 states fail to offer the spouses of waiver participants the full level of income and/or asset protection afforded the spouses of nursing home residents by the feds.
- 13 states protect neither income nor assets of spouses of waiver participants.
- 8 states protect assets but not incomes of the community spouses of waiver participants.

The Deficit Reduction Act of 2005 (DRA)

- Requires states to apply the “income-first” rule (maximum allowable as to LTC spouse income) to community spouses appealing for increased resource allowance based on need for more funds invested to meet their minimum income requirements.
- Authorizes states to include home and community-based services as an optional Medicaid benefit. (Previously, states had to obtain a waiver to provide such services.)
**ASSET TRANSFER PENALTIES**

Penalty calculated by dividing the transferred amount by the state’s average monthly Medicaid nursing home cost. States publish their monthly average cost at least yearly. QUOTIENT PROVIDES THE NUMBER OF MONTHS THE PATIENT MUST PAY HIS OR HER OWN LTC COSTS

Four years prior to LTC need, Bill alienates $500,000.00 to his children (home sale, irrevocable trust, sale of real property, jewelry, art collection). Avg. State Monthly NH Expense = $5000.00

Bill must pay 100 months (over 8 years) of his own LTC expense prior to qualifying for Medicaid coverage.

After look back lapses, Medicaid cannot assess a penalty.

Bill would do better to pay for himself for one year.

**TRANSFER OF HOME WITHOUT DRA PENALTY**

- transfer to applicant’s spouse or child under 21 or who is blind or disabled
- transfer into trust for the sole benefit of disabled person under age 65 (even if trust is for the benefit of applicant, under certain circumstances)
- transfer to sibling living in the home during the year preceding the applicant’s institutionalization and already holding an equity interest in the home
- transferred to “caretaker child,” a child of applicant living in the house for at least two years prior to NH and who provided care allowing applicant to avoid a NH stay.

**CAVEATS**

- SINGLE ELDERLY LIKELY TO NEED LTC – CONSIDER CARETAKER CHILD OR SIBLING – ALSO SPEND DOWN TO MEDICALLY-NEEDED LEVEL IF POSSIBLE
- MOVE INTO MORE MODEST HOME EARLIER IN LIFE
- GIFT ASSETS TO CHILDREN AS EARLY IN LIFE AS POSSIBLE
- CONSIDER A LONG-TERM CARE INSURANCE POLICY
- KEEP YOUR SPOUSE HEALTHY
- CONSIDER A TRUST FOR BENEFIT OF LTC RECIPIENT AND FORM EARLY
- MOVE TO A STATE WITH HIGHER WAIVER VALUES
- INVESTIGATE A MILLER TRUST (PAYS FOR CABLE, FLOWERS, PERSONAL CARE)
- SOMETIMES ITS BEST TO WAIT A WHILE TO APPLY FOR MEDICAID

**ACLM - 2015**

PLEASE JOIN US FOR THE ANNUAL MEETING OF THE AMERICAN COLLEGE OF LEGAL MEDICINE IN beautiful AUSTIN, TEXAS februARY 25 THROUGH 28, 2016!
The Role of Medical-Legal Partnership in Helping Vulnerable Populations

Presented by
Keegan Warren-Clem, JD, LLM
American College of Legal Medicine
65th Annual Meeting
February 28, 2016

Objectives
1. Deepen understanding that socio-legal determinants significantly impact a patient's health and affect low-income patients more dramatically
   a. Companions: Medical Knowledge (social-behavioral), Patient Care, Professionalism
2. Redefine the social history as mechanism for information from the patient about his/her socio-legal determinants of health
   a. Companions: Patient Care, Systems-Based Practice (patient advocacy), Interpersonal Communication Skills
3. Develop a working knowledge of the I-HELP model and its basic principles to use for patient treatment and advocacy
   a. Companions: Systems-Based Practice, Professionalism

When I-HELP
Income & insurance
Housing
Education & employment
Legal status
Personal stability

“...The relationship between patient and physician is based on trust and gives rise to physicians’ ethical obligations — to advocate for their patients’ welfare.”
—AMA Code of Medical Ethics, Opinion 3.011, “The Patient-Physician Relationship

Why I-HELP with Income & Insurance
• Most diseases are more prevalent amongst the poor, and those that are not, such as breast cancer, tend to have worse outcomes for the poor.6
• Both the material and psychosocial health effects of adequate financial resources correlate positively with improved health.7
• Healthcare insurance is a proxy for access to care. Without it, patients suffer from missed preventive and diagnostic services, poor management and control of health problems once they occur, and increased morbidity and lower levels of functioning once ill.3

What is medical-legal partnership (MLP)?
• MLP is a healthcare delivery model that incorporates legal assistance into patient care to address health-harming legal needs.
• MLP lawyers work onsite in the clinical or hospital setting as auxiliary members of the healthcare team.
• Favorable resolutions from national organizations
  • American Medical Association
  • American Academy of Pediatrics
  • American Academy of Family Physicians
  • American Bar Association

What I-HELP with Income
• Sample legal issues
  • Wrongful denials, delays, or cuts in benefits, or claims of overpayment
    • Supplemental Nutrition Assistance Program (food stamps)
    • Temporary Assistance for Needy Families (cash assistance)
    • Women, Infants, & Children program
    • Social Security Disability Insurance or Supplemental Security Income

February 26, 2015
What I-HELP with Insurance

- Sample legal issues
  - Wrongful denial of eligibility or Rx/Rx coverage, reductions in coverage/services, or determinations of ineligibility
  - Medicaid
  - Children's Health Insurance Program
  - Medicare
  - Tricare
  - Private or other health plan

What I-HELP with Housing

- Sample legal issues
  - Denials of tenancy, threatened evictions, utility cut-offs, unhealthy conditions
  - Government rental housing (public, subsidized, Section 8, etc.)
  - Private rental housing
  - Wrongful foreclosure

How I-HELP with Income & Insurance

- Potential legal remedies (income)
  - Informal oral/written advocacy
  - Appeal by administrative process/hearing
  - Appeal by lawsuit

- Potential legal remedies (insurance)
  - Internal appeal
  - Appeal by administrative process/hearing
  - Appeal by lawsuit

How I-HELP with Housing

- Potential legal remedies
  - Informal oral/written advocacy
  - Internal appeal
  - Appeal by administrative process/hearing
  - Appeal by lawsuit

Why I-HELP with Housing

- Poor housing quality is associated with morbidity related to infectious and chronic diseases, injuries, poor nutrition, asthma, neurologic damage, and mental disorders.1
- Ten percent of the global disease burden derives from inadequate sanitation,2 and a steady source of energy is widely considered a prerequisite to good health.3
- Long-term homelessness is a significant predictor of poor health and is associated with a high incidence of acute and chronic health problems and premature mortality.3

Why I-HELP with Education & Employment

- The better educated live longer, are less likely to have and die from common acute and chronic diseases, are less likely to be overweight or obese, and are less likely to engage in health-harming behaviors.1
- Education matters for health not just because of the specific knowledge one obtains in school, but rather because education improves general skills, including critical thinking skills and decision-making abilities.2
- Employment issues are linked to poorer health outcomes, including in children of parents facing workplace issues.3
What I-HELP with Education

• Sample legal issues
  • Refusal by school to test for disability
  • Refusal by school to modify curriculum or accommodate disability per IEP/IBP/504 plan
  • Refusal by school to enroll student due to kin care, homelessness, or immigration status
  • Inappropriate school discipline

What I-HELP with Legal Status

• Sample legal issues
  • Credit history
  • Bankruptcy
  • Immigration
  • Unaccompanied minor
  • Removable legal status
  • Veterans
  • Wrongful less-than-honorable discharge

What I-HELP with Employment

• Sample legal issues
  • Wage theft
  • Discrimination
  • Unsafe working conditions

Why I-HELP with Legal Status

- The presence of unmet loan obligations is associated with higher rates of suicidal thoughts and depression, along with poorer subjective health assessments and health-related behaviors.1
- Fear of imprisonment and removal (deportation) impedes immigrant access to care.2
- Veterans with less-than-honorable discharges are less likely to have access to care and are more likely to engage in health-harming behaviors.3

How I-HELP with Education & Employment

• Potential legal remedies
  • Oral and written advocacy
  • Appeal by administrative process/hearing
  • Appeal by lawsuit

How I-HELP with Legal Status

• Potential legal remedies
  • Affirmative request for relief
  • Appeal by administrative hearing
  • Appeal by lawsuit
What I-HELP with Personal Stability

- Sample legal issues
- Adult guardianship
- Advance care planning
- Divorce
- Kincare
- Powers of attorney
- Wills

Why I-HELP with Personal Stability

- Marital disruption affects health through stress and the loss of health-enhancing resources (i.e., income and insurance).
- High conflict during divorce is associated with long-term, serious physical health problems for children.
- Advance directives and powers of attorney generate open communication; reduce stress for the patient, the family, and the provider; and are important for minimizing unwanted care (and individual/systemic costs) by patients unable to make their own healthcare decisions.

Case Study

Claudia, single mother of 2 children, is diagnosed with stage 3 breast cancer. She needs multiple healthcare visits for diagnosis and staging.

Claudia goes through treatments and manages challenges with her health care, but also must juggle the stress and demands of family life.

After losing her job, Claudia has no insurance and she and her children are suddenly facing medical bills and loss of health care benefits.

CLAUDIA could have helped Claudia access federal healthcare benefits, but she was not aware of the assistance.

What I-HELP with Personal Stability

- Potential legal remedies
- Drafting of legal documents
- Lawsuit

Law and Ethics Beyond the Patient’s Issues

- Attorney Access to Electronic Medical Records
- Attorney Client and vs. Provider Patient Confidentiality
- Healthcare Entity-Client Conflicts
- Healthcare Funding for MLP
  - Hospital Community Benefit
  - HRSA Case Management Services
  - HRSA Funding Services
  - CMS Billing Code (WV Reimbursement)
- In-house Counsel
- Medical vs. Legal Patient/Client Research
- Unauthorized Practice of Law by Providers

- Number of MLP-related
  - Liability lawsuits?

- Number of MLP-related
  - Board/bar sanctions?

How I-HELP with Personal Stability

- Potential legal remedies
- Drafting of legal documents
- Lawsuit

15,000 healthcare providers rated annually

60,000

55

136

70

National Center for Medical Legal Assistance

February 26, 2015
Contact Information

Austin Medical-Legal Partnership

- Keegan Warren-Clem, JD, LLM
  - e: kwcclem@austinpc.org
  - d: (512) 684-1714
GENERAL SESSION VI

ETHICAL DILEMMAS WITH VULNERABLE AND SPECIAL POPULATIONS (ETHICS)

SUNDAY, FEBRUARY 28, 10:45AM - 12:15PM

Grand Ballroom A

MODERATOR:
Karin M. Zaner, JD, FCLM
ACLM 2016
Ethical Issues in the Vulnerable

Giving Bad News
The Vulnerable Patient

Bartering Patient

List Jumper
Abusing Anatomical Gift Donor’s Family?

Donate Kidney Minor Sibling – How Voluntary?

Abusing Vulnerable Non-Compliant Patient?

We’re not necessarily bad people or bad patients. We just have mental barriers to doing what’s right for our bodies.
DENTAL SESSION II

FRIDAY, FEBRUARY 26, 10:00 AM - NOON

Brazos

MODERATOR:
Joseph P. Graskemper, DDS, JD, FCLM, DABMM
Title IX

No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving federal financial assistance.

History

- The Civil Rights Act of 1964 was enacted to end discrimination based on religion, race, color, or national origin.
- Did not include prohibition of gender discrimination in public education and federally assisted programs.

History

- Senator Birch Bayh (IN) along with Rep. Patsy Mink (HI) worked on women's issues, including the Equal Rights Amendment.
- Since the Equal Rights Amendment was not moving forward quickly, Bayh introduced the equal education provision of the ERA as an amendment to the revision of the Higher Education Act.
History

• This provision became known as Title IX, which was signed into law on June 23, 1972 by President Richard Nixon.
• Was renamed the Patsy T. Mink Equal Opportunity in Education Act in 2002 in memory of the co-author.

Implementation

• Oversight of Title IX enforcement and implementation is the responsibility of the Department of Health and Human Services Office for Civil Rights.

Impact

• Title IX is most famous for changes in athletic programs to offer opportunities for all athletes, regardless of gender.
• Less well known is the impact of Title IX on sexual harassment and sexual violence in educational programs.

Sexual Harassment/Sexual Violence

• Title IX applies to all educational programs and all aspects of a school's educational system.
• In 2011, the Office of Civil Rights issued the “Dear Colleague” letter.
• The letter states that it is the responsibility of institutions of higher education "to take immediate and effective steps to end sexual harassment and sexual violence."

• "The sexual harassment of students, including sexual violence, interferes with students' right to receive an education free from discrimination and, in the case of sexual violence, is a crime."
• Should an institution fail to fulfill its responsibilities under Title IX, the Department of Education can impose a fine and potentially deny further institutional access to federal funds.

• Under Title IX guidelines, harassment is considered to be conduct that creates an impermissible hostile environment if it is "sufficiently serious that it interferes with or limits a student's ability to participate in or benefit from the school's program." Less severe conduct with sufficient repetition may rise to this level, while even one incident that is more serious may rise to this level.
Sexual Harassment/Sexual Violence

- The scope of sexual violence covered by Title IX includes an array of offense categories, including rape, sexual assault, sexual battery and sexual coercion.
- Specifically defined as “any sexual act directed against another person, forcibly and/or against that person’s will; or not forcibly or against the person’s will where the victim is incapable of giving consent.”

Off Campus Sexual Harassment

- The harassing conduct may occur in any setting related to a school’s programs, including off-campus activities such as field trips or athletic events.
- This is especially true when it rises to the level of sexual violence that originally happened off campus or outside an educational program if a student experiences “the continuing effects of off-campus sexual harassment” in an educational setting.

Which leads me to the case study…

The Case Study

- The Setup
- The Trip
- The Story
- The Notification
- The Interview
- The Board of Conduct
- The Penalty
- The Aftermath
Private Practitioner’s Guide to Social Media

SOCIAL MEDIA AND THE PRIVATE PRACTITIONER
8th Annual Ethic and Legal Aspects of Dentistry Conference
Dental Session II
Renaissance Hotel– Austin, TX
February 26, 2016
11:15 a.m. – 12:00 p.m. noon

KARIN M. ZANER, J.D.
KANE RUSSELL COLEMAN & LOGAN PC
1001 Elm Street, Suite 3700
Dallas, Texas 75201
(214) 777-4203
kzaner@krcl.com

UNDERSTANDING SOCIAL MEDIA: TOP 10 TIPS

1. BE AWARE OF THE EFFECT OF SOCIAL MEDIA
- Standards of dental care do not change by virtue of the tools used to interact;
- For example, Section 106.001 of the Texas Dental Practice Act, Chapters 251 through 267 of the Texas Occupations Code (states that “the fact that an activity occurs through the use of the Internet does not affect a licensing authority’s power to regulate an activity or person that would otherwise be regulated under this title”);
- Social Media tools are powerful;
- May have unforeseen consequences;
- Depends on the type of social media and how used;
- And most importantly–

2. WARNING: DO NOT BECOME A BAD HEADLINE
- Dallas anesthesiologist being sued over deadly surgery admits to texting, reading iPad during procedures

3. WARNING: DO NOT BECOME A BAD HEADLINE, cont’d.
- Local anesthesiologist trashes sedated patient — and it ends up costing her

4. USE YOUR SOCIAL MEDIA POWERS FOR GOOD, NOT EVIL–
KEEP CURRENT WITH MEDICAL NEWS AND DEVELOPMENTS

- Resources abound
- Make sure they are reliable dental authority
- State Laws, Rules/Regs (Texas Dental Practice Act)
- Check State Licensing websites
- Written Materials, Videos, Updates
- News and Journals

MAINTAIN PROFESSIONAL PRESENCE
ENRICH PROFESSIONAL NETWORK

- Use Facebook, LinkedIn, Twitter, other social media sites to
  - maintain your professional presence and
  - connect with colleagues, referral sources, and patients.
- Can a patient can "like" your personal Facebook page?
  - Where will this go?
  - Patient "likes" you; patient comments and you comment back;
  - Patient sends you a picture of her broken crown;
  - Patient makes concerning comments (suicide) or engages in risky activities?
  - Do you respond? What do you do with information?
  - What if you don’t respond? What if something happens?
  - What if you don’t check your account?
  - Patient abandonment per Texas Dental Practice Act Rule 108.5?

MAINTAIN PROFESSIONAL PRESENCE
ENRICH PROFESSIONAL NETWORK

- Can a patient can "like" your Facebook page?
- Use cocktail party analysis;
- If any issues come up, be general;
- Always route through regular patient intake and practice communications channels for your practice;
- If urgent or emergent, direct to 911 / ER room.
- Make sure that all credentials, representations, and claims are
  - Accurate and current
  - and do not constitute false advertising.

EDUCATE AND INFORM YOUR PATIENTS

- Ethical Standards in the Federation of State Medical Boards Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice, (2013), are generally reflected Texas Dental Practice Act, as well as its rules and regulations:
  - **Candor:** Practitioners have obligation to disclose any information (financial, professional, personal) that could influence patients’ understanding of use of the information, products, services offered on website (Section 254.002, 258.050-007 deals with advertising; Rules 108.53-108.63 on fees, advertising of fees, and websites).
  - **Integrity:** Information contained on websites should be truthful, accurate, concise, up-to-date, and easy for patients to understand, no false statements to patients, Section 259.001; deferring as unprofessional conduct, Section 259.008; Rule 108.1 on professional responsibility; Rule 108.2 on fair dealing).
  - **Privacy:** Practitioners have obligation to prevent unauthorized access to or use of patient and personal data, and to assure that de-identified data cannot be linked back to user or patient (access to dental records, Section 258.051; dental privilege, Section 258.101-108).

EDUCATE AND INFORM YOUR PATIENTS
General advice specific to your subspecialty – can be posted on professional pages
– Can be discussed in blogs.
– Make sure information current
– Patient friendly and meaningful to your audience.

Avoid disclosing Protected Health Information (PHI) that you obtain on a patient as a treating practitioner.
– Never use specific patient details – revealing details of dental care – may violate HIPAA and patient privacy laws
– Focus instead on – general conditions and treatment options – at a community level.

• What is Protected Health Information?
• All “individually identifiable health information”
• Held or transmitted by a covered entity or its business associate,
• In any form or media, whether electronic, paper, or oral.
• RULE OF THUMB: If it contains any type of health data (including payment information) and identifies the individual or there is a reasonable basis to believe it can be used to identify the individual, it is PHI.

• Who is a Covered Entity?
• Health plans,
• Health care clearinghouses,
• Health care providers (includes practitioners) conducting certain financial and administrative transactions electronically (e.g., claim submission, billing, and fund transfers),
• Active practitioners should assume "covered entity" status.
HIPAA REFRESHER, CONT’D.

- What is a PHI breach?
- Any impermissible disclosure of PHI is a breach unless “low probability that PHI was disclosed.” Examples—
  - Forwarding e-mails outside of hospital/healthcare entities e-mail addresses (to personal accounts);
  - Accessing and viewing PHI (electronic trail remains);
  - Disclosing PHI on social media (ConsultantLive);
  - Online New York Times Magazine “Diagnosis” column—depends on how much PHI detail given;
- Closed practitioner networks (e.g., possibly sites like Sermo, Medscape, Quanta MD).

Don’t be a target by disclosing any PHI on social media, even with privacy settings!

HIPAA violations have now become a focus—
- Given visible public enforcement efforts; and
- Current technology that makes them easier to prove.

Avoid even the appearance of a HIPAA violation.
Don’t give an easy peer review ground.
Once discovered, healthcare entity may have to follow through.

BE A COMMUNITY RESOURCE

- Always keep in mind your professional image to the public.
- If you link to other websites,
  - verify them as reliable authority
  - always give credit when due
  - beware if unsure about 3rd party compliance (i.e. ConsultantLive e-mails).

ASSIST COLLEAGUES OR OBTAIN ASSISTANCE

- Closed practitioner networks (such as Sermo, Medscape, Quanta MD)
  - allow practitioners to disclose general patient conditions
  - solicit input from colleagues.
- Avoid specific details and photographs (esp. of facial areas and teeth) that may violate HIPAA and patient privacy laws.
- Even if other practitioners participate
  - Even though they are closed networks
  - Is disclosure of PHI is legal or allowed?

AVOID GIVING MEDICAL ADVICE OR TREATMENT

- In using social media, a provider must
  - absolutely guard the PHI obtained as a covered entity under HIPAA
  - and avoid accessing PHI of non-patients.
- A provider should not disclose any PHI to any third party via social media, even with privacy settings.

CONSIDER RECORDINGS “OFF LIMITS”

- While it may not be illegal in your state to record a conversation or interaction over the phone or in person if
  - you are a party to it (check state law),
  - never surreptitiously record any patient interaction.
  - remember this is a healthcare environment.
- Think twice before doing so even with patient consent and
  - never post recordings on YouTube or any other such site,
  - even with privacy settings.
- But keep in mind, the patient may be recording you so act and talk professionally and respectfully at all times!
**OKAY TO MAINTAIN PERSONAL SOCIAL MEDIA**

- Having a Facebook page or a personal blog is acceptable as long as
  - the content "does not undermine the public trust in the profession."
  - what is that? Glass of Wine v. Obviously Intoxicated?
  - RULE OF THUMB: Avoid "frat party pictures" that mom would not like to see.

- Be vigilant in keeping personal social media sites personal

- Direct patients asking for clinical advice through regular practice intake and communications channels.

**USE YOUR GOOD JUDGMENT**

- If concerned, just say no.

- Examples — Federation of State Medical Boards Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice, 2013
  - Urologists posts disrespectful comments
  - Physician refers to a patient as "lazy and ignorant" on blog
  - Former patient’s "friends" practitioner on Facebook
  - Former patient’s posts worry practitioner on Facebook
  - Concerned patient notices practitioner is "partying"
  - Physician asks patient out on online dating website
  - First-year resident films doctor inserting chest tube; posts on YouTube

- Don’t become an online example of bad judgment.

**AVOID SOCIAL MEDIA PITFALLS: TOP 10 TIPS**

**REFRAIN FROM POSTING IDENTIFIABLE PHI ONLINE**

- Never disclose on social media or publicly—
  - Names, DOBs, contact information,
  - photographs, x-rays,
  - details of patient care,
  - even when the patient asks you.
  - obtained as a covered entity from a patient.

- See AMA Opinion 9.124 (a).*

**SOCIAL MEDIA CREATES A PUBLIC AND PERMANENT RECORD**

- An electronic trail is left.

- Can be disseminated to third parties in an instant.

- Think ahead before you press "send" or "post."

**MAKE NO ASSUMPTIONS OF PRIVACY**

- Use privacy settings so as to safeguard your own personal information and content;

- But privacy settings are not absolute.

- Monitor content posted about you by others to ensure propriety and accuracy.

- See AMA Opinion 9.124 (b).*

---

* American Medical Association Code of Medical Ethics Opinions on Confidentiality of Patient Information: Professionalism in the Use of Social Media (June 2011).
**MAINTAIN PROPER BOUNDARIES**

- Just as in any other context (personal, telephone), when interacting with patients via social media, a provider must maintain appropriate boundaries for the relationship.
- in accordance with professional ethical guidelines.
- See AMA Opinion 9.124 (c).*

* American Medical Association Code of Medical Ethics Opinions on Confidentiality of Patient Information: Professionalism in the Use of Social Media (June 2011).

**KEEP BUSINESS SEPARATE FROM PERSONAL**

- See AMA Opinion 9.124 (d).*
- Monitor to make sure that interactions with patients remain consistent with business purposes.
- If specific clinical advice is sought through a personal Facebook inquiry,
  - direct them instead to your professional page.

* American Medical Association Code of Medical Ethics Opinions on Confidentiality of Patient Information: Professionalism in the Use of Social Media (June 2011).

**AVOID QUESTIONABLE CONTENT**

- Unprofessional content (business or personal)
  - can be viewed by state dental boards, professional societies, and health care entities
  - as undermining public trust in the dental profession
  - may create a basis for adverse action.
- See AMA Opinion 9.124 (f).*

* American Medical Association Code of Medical Ethics Opinions on Confidentiality of Patient Information: Professionalism in the Use of Social Media (June 2011).

**UNPROFESSIONAL CONTENT OF COLLEAGUES**

- Unprofessional content posted by colleagues,
  - Bring to attention and suggest removal;
  - if not removed, may possibly require reporting to these same authorities.
- See AMA Opinion 9.124 (e).*
- Unclear if this affects dental practitioners but may be best practice.

* American Medical Association Code of Medical Ethics Opinions on Confidentiality of Patient Information: Professionalism in the Use of Social Media (June 2011).

**KEEP ONLINE RESPONSES GENERAL**

- Create and maintain a social media policy (no offensive postings, no HIPAA and/or privacy violations, etc.).
- Do not reveal a patient’s PHI acquired in a clinical setting.
- Keep postings and online responses general and non-specific to patient.
- Instead of specific response (this may be a HIPAA violation, even if the patient first raises the issue), request that the patient
  - make a clinical appointment
  - inquire to your office by telephone.

**EMPLOYED PRACTITIONERS SHOULD ASK**

- If you are an employed practitioner,
  - follow any social media policies
  - get approval from employer for specific posts.
- Avoid disclosing proprietary and trade secret information.
- For personal accounts of practitioner, consider using a disclaimer stating:
  - posts are personal views;
  - not those of the employer.
MAINTAIN BLOGS

- Blogs require attention monthly, if not weekly.
- Avoid discussing
  - specifics of patient care
  - malpractice cases
  - peer review or licensing matters
- Improper advertising (promise results/ misleading)?
- Add a disclaimer?

RATINGS WEBSITES

- What does a practitioner do?
- Determine what Yelp, Angie’s List, Rate MDs.com, and HealthGrades are saying about your practice.
- Defamation suits against patient unlikely to succeed.
- Also defer to ACLM speaker Jeffrey Segal, M.D., J.D., Medical Justice Services, Inc. / Dental Justice / eMerit.

PAY ATTENTION TO YOUR ONLINE PRESENCE

- Separate personal from business;
- Keep resources current and accurate;
- Direct patients through regular practice channels;
- Before you respond or post (especially PHI), THINK;
- Put time and effort towards your online presence.
- If you don’t, your practice may look deficient.

FINAL NOTE: MOBILE DEVICES

- Special attention to mobile devices—
  - www.healthit.gov/mobiledevices (hard copy in materials)
  - For any mobile devices that contain PHI,
  - Maintain physical control at all times;
  - Use encryption and passwords;
  - Installing firewall and remote disabling software;
  - Use adequate security when using public Wi-Fi networks;
  - Deleting all PHI before discarding any device.
DENTAL SESSION III

FRIDAY, FEBRUARY 26, 1:00 PM - 2:45 PM

Brazos

MODERATOR:
Bruce Seidberg, DDS, MScD, JD, FCLM
FRAUD ALLEGATIONS AGAINST THE HEALTHCARE PROVIDER: A PERSONAL EXPERIENCE: WHAT IF YOU FIND YOURSELF ON THE RECEIVING END OF PROSECUTORIAL MISCONDUCT?

MORSE V. SPITZER
07-CV-47931

MY AUDIT HISTORY

AUGUST 2002 3RD MEDICAID AUDIT

2005 THE AG, SPITZER, RUNS FOR NEW YORK GOVERNOR

PRIOR AUDIT RESULTS FOR DR. LEONARD MORSE

<table>
<thead>
<tr>
<th>Audit #</th>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/20/2001</td>
<td>$771.00</td>
<td></td>
</tr>
<tr>
<td>01/27/2002</td>
<td>$1,738.15</td>
<td></td>
</tr>
<tr>
<td>06/01/2003</td>
<td>$13,093.00</td>
<td></td>
</tr>
<tr>
<td>07/02/2003</td>
<td>$2,018.30</td>
<td></td>
</tr>
</tbody>
</table>

THE TOTAL OF ALL PRIOR COMPREHENSIVE AUDITS = $23,110.20
SECOND CIRCUIT COURT OF APPEALS:
OMISSION OF TOOTH NUMBERS WAS "UNAVOIDABLE"
ASK FOR QUALIFIED IMMUNITY
PLEAD GENERAL VERDICT RULE

THE GOVERNMENT'S 2ND CIRCUIT COURT OF APPEALS MOTION:
TOOTOE NUMBERS ARE
EXEMPLARY EVIDENCE AND
NOT A MATERIAL ISSUE OF FACT.
THERE IS NO CONSTITUTIONAL
REQUIREMENT OR OBLIGATION
THAT THEY BE INCLUDED IN ANY
SUMMARY OF DATA PRESENTED
TO A GRAND JURY.
IF DR. MORSE PREVAILS IN THIS
CASE PROSECUTORS IN AMERICA
WILL NO LONGER BE ABLE TO
PURSUE WHITE COLLAR AND
FINANCIAL FRAUD CRIMES!!

THE THREE KEY THINGS YOU NEED TO DEFEND YOURSELF:
RECORDS
RECORDS
RECORDS

THE WISDOM OF PERICLES
(495-429 BC)
JUST BECAUSE YOU DO
NOT TAKE AN INTEREST
IN POLITICS DOESN'T
MEAN POLITICS WON'T
TAKE AN INTEREST IN
YOU!!!
THE ANTI SLITZER SENTIMENT
ARRAIGNMENT IN CRIMINAL COURT

"WHEN THE ELECTION IS OVER YOUR PROBLEMS ARE OVER"

THE PROTEST AT THE OFFICE OF THE ATTORNEY GENERAL: ELIOT SPITZER

"THE PEOPLE UPSTAIRS WANT THIS CASE TO CONTINUE"

THE CRIMINAL TRIAL
JUNE 2007, BENCH NOT JURY
TRIAL ON A 3-FELONY

CRIMINAL TRIAL MISCONDUCT:

MY CHARTS ARE "LOST"
NO WITNESS LIST PROVIDED
ROSADEO MATERIAL WITHHELD
SECRET WITNESS: DR. GOLBER
PROSECUTOR'S CLOSING SIMULATION
PROSECUTOR RETIRES BEFORE VERDICT ANNOUNCED

WHO ARE YOU GOING TO CALL WHEN YOU WANT TO SUE ELIOT SPITZER ??????

PROSECUTORIAL PROTECTIONS

ABSOLUTE IMMUNITY
QUALIFIED IMMUNITY
PROBABLE CAUSE
ARGUABLE PROBABLE CAUSE
HARMLESS ERROR
11/16/2007
FEDERAL CIVIL
RIGHTS LAWSUIT
42 U.S.C. SECTION
1983
MALICIOUS PROSECUTION
FALSE ARREST
STIGMA PLUS CLAIM
DENIAL OF A FAIR TRIAL DUE
to fabrication of the
evidence

FEDERAL MAGISTRATE
RULINGS
1. RELEASE OF GRAND JURY
TRANSSCRIPTS UNREDACTED.
2. DEPOSITIONS WILL TAKE PLACE
3. THERE WILL BE DISCOVERY

DISCOVERY
21,000 DOCUMENTS TURNED OVER
"SMOKING GUN": THE EVD
PROSECUTOR'S EMAILS
SPOLIATION OF EVIDENCE
"ILLUSTRATIVE BILLINGS"
G.J. EXHIBIT #7
G.J. EXHIBIT #11: SUPER PATIENT
GRAND JURY ORIGINALS LOST
DATE ALTERATIONS EXECUTED
CHECK DATA DELETED

ARE THE TOOTH NUMBERS (A
MANDATORY FIELD ON ALL
DENTAL BILLING INVOICES)
A MATERIAL ISSUE OF FACT
OR SIMPLY AN EXAMPLE OF
EXCULATORY EVIDENCE
WHICH CAN BE EXCLUDED
FROM ANY PRACTITIONERS
BILLING SUMMARIES ??

Grand Jury Exhibit #7
Six Added Lines of Billing
Grand Jury #11
"Super Patient"
THE “GOOD PERJURY” V. PLAIN OLD PERJURY EXPLANATION!
MARCH 11, 2008
ELIOT SPITZER GOES DOWN IN FLAMES IN A SEX SCANDAL AND RESIGNS AS GOVERNOR OF NEW YORK STATE

PETTIFOGGING
TWO YEARS ARE WASTED WITH THE GOVERNMENT FILING SUMMARY JUDGMENT MOTIONS

THE GOVERNMENT “EXPERT” WITNESSES
LINDA DELUCA, DENTIST
NOT A LICENSED PROVIDER
PAID SPOKESPERSON FOR AG DOES NOT KNOW ANY CODES
WORKED 3 HOURS IN OFFICE
JOSE CASTILLO, AUDITOR
NOT A CPA
NOT A STATISTICIAN
PRIOR JOB – HEAD WAITER
JON HUNT, PROSECUTOR
PERFECT STORM OF AEROGANCE, LAZINESS & INCOMPETENCE

THIS IS HOW MANY TIMES CASTILLO SAID THE FOLLOWING ANSWERS AT HIS DEPOSITION:
"IT IS POSSIBLE" 86 TIMES
"I DON'T REMEMBER" 13 TIMES
"I'M NOT SURE" 13 TIMES
"I MIGHT HAVE BEEN ME" 1 TIME
"I DON'T KNOW" 47 TIMES
"I DON'T HAVE AN EXPLANATION" 4 TIMES
"I GUESS" 1 TIME
"A POSSIBILITY" 1 TIME

THE FEDERAL CIVIL RIGHTS TRIAL
AUDITOR TESTIFYS DOCUMENTS WERE CREATED DURING THE INVESTIGATION
VERDICT SHEET: SPECIAL INTERROGATORY
JURY SENDS JUDGE A QUESTION
FINAL JURY VERDICT
JULY 8, 2013 ELIOT SPITZER
TRYS FOR A POLITICAL COMEBACK
Fun with Coding 2016

• ACLM Annual Meeting
  • FEB 2016
  • Austin, TX
    • Daniel L. Orr II, DDS, MS (anesth), PhD, JD, MD
    • Professor and Director
    • OMS and Anesthesiology
    • UNLV SDM

CDT vs ICD-10

• Another reason it is treat to be a dentist, relatively speaking at least:
  • CDT codes ≈ 650
    – (Very hard to comply)
  • ICD-10 codes ≈ 140,000
    – (Impossible to comply)

UNLV SDM History, Ancient

• In January 2008 OMS faculty were directed to sign thousands of incomplete charts from prior years (for CODA)
• Chart review (via statute and insurance industry standards): records were unsigned and a significant majority of procedures were improperly coded

UNLV SDM History, Less Ancient

• 2008 OMS/ER paradigm = pre-op undercoding, i.e. with default 7140 extractions, charging less for Sx than material cost, etc.
• Patients were upset with additional fees status post Sx when advised procedure was actually not optimally coded
• One correction: 2009 OMS/ER clinic changed default extraction to 7210
• Patients were happy when receiving more accurate estimates and refunds

History, Current Issues, I.E.:

• OMS charges $150.00 for bone grafting, materials cost $286.00+
• Team patients of record (POR) for multiple extractions without pre-op alveoloplasties. Alveoloplasties are added at Sx or later (at a higher fee) than if optimally planned
• July 2009 POR exts coded 7140 that were actually ≥ 7140, i.e. 7210, 7220, 7230, and 7240

Tx Planning, principles

• 1st: No such thing as a “simple” ext
  – Orr, LM, 1980 (and BTW, CDT nomenclature)
• 2nd: Codes are developed to reasonably reimburse based on relative difficulty of procedure (i.e. often the time involved to perform)
• Nomenclature: Definition of the code
• Descriptor: Further definition of the intended use of the code
In 1986 the ADA determined to develop an educational manual:

Code review and revision is a dynamic process. Individuals can participate at:
– www.ada.org/goto/dentalcode

Billing to third parties often requires a code
– There may be more than one code that describes a procedure
– There are two types of codes where a narrative must be included on the claim submission
  – When nomenclature requires a narrative
  – When none of the codes accurately describe the services

Ta Daaaa, CDT 2016

7140 Definition: “Erupted”

Questions:
– What is an erupted tooth?
– When is a tooth erupted?

Eruption: “The final state of odontogenesis, in which a tooth breaks out from its crypt through the surrounding tissue.”
– Dorland’s 31st

Questions:
– Is “Erupted” just breaching ST, in functional occlusion, or somewhere in-between?
– Does it matter if the process involved is active or passive eruption?

Active Eruption: “The continued eruption of the teeth after complete formation of their dentinal roots, consisting of movement of the teeth in the direction of the occlusal plane, and being coordinated with attrition.”

Passive Eruption: The apparent eruption of a tooth that is actually the exposure of the crown of the tooth by separation of the epithelial attachment from the enamel and migration to the cementoenamel junction.” (Dorland’s 31st)
**7140 Definition: “Exposed Root”**

- Questions:
  - Does “exposed root” mean no soft tissue, no bone, or both?
  - What if there is a crown attached?
  - What if the root is laying on the gingiva?

**7140: “Elevation”**

- Questions:
  - *Elevation*: Of what? Tooth, ST, bone?
  - Does “Elevation” = elevator?
    - What if one elevates with forceps?
    - What if one elevates with a periosteal elevator?
    - What if one elevates hydraulically?
    - What if one elevates with elastics?
    - What if one does elevate with a dental elevator?
      - Does use of an elevator equate to 7140?
      - What if one uses an elevator to remove bone?

**7140: “Forceps”**

- Is there a difference?
  - Between removing a clinically mobile, non-root fractured, single rooted tooth with a 62 forceps and
  - Using the 62 forceps to displace soft tissue, remove bone, and deliver an ankylosed 28mm maxillary cuspid?

**7140 Definition: the fine print**

- Questions:
  - What is “routine” removal of tooth structure?
    - CDT: written for GP’s or OMS’s?
    - Is what is routine for a GP routine for an OMS?
  - What is “minor” smoothing of socket bone?
    - Is it rasp vs rongeur vs bur?
    - Is it 2-3 rasp swipes vs 4-5?
  - What is “closure, as necessary”?

Another Question…

- How does one code a tooth that is removed without a forceps or elevation?
  - i.e. with gauze, dental floss and a doorknob, by hand, with a rongeur?
  - i.e. a planned 7140 that is displaced into the hypopharynx, GI system, respiratory system, maxillary sinus, infratemporal fossa, floor of mouth, as part of a resection, to complete a traumatic subluxation, etc., etc., etc.?

**7210 Definition: “Surgical” and “Flap”**

- “Surgical”: “Tx…by manual or operative methods” (Dorland’s 31st)…so even 7140 is technically a ________ procedure
- *Mucoperiosteal flap* questions:
  - Does that include subgingival placement of an elevator to split roots?
  - Does that include stripping the PDL?
  - Does that include a really small flap, i.e. subperiosteal elevation of the gingival cuff?
7210 Definition: “Flap” (cont.)

- **Mucoperiosteal flap** (cont.):
  - Does it matter if the flap is unintentional?
  - I.E. partially degloving the alveolus for a 7140, does that indicate a flap was “required” even though operator deferred?
  - I.E. damage to adjacent HT and ST:
    - Bone, teeth, restorations, soft tissues
    - 7210: “Includes cutting of gingiva…”
    - 7140: No mention of ST manipulation during “elevation and/or forceps” extraction

7210 Definition: “Bone”

- **Requiring removal of bone** questions:
  - What if bone is spontaneously removed with the tooth, i.e. between roots?
  - What if one didn’t intend to remove bone but did anyway?

7210 Definition: “section of tooth”

- **Requiring section of tooth** questions:
  - Is tooth “sectioned” by any intentional split, i.e. with bur, elevator, forceps, osteotome?
  - Is tooth “sectioned” by unintentional split, i.e. broken dilacerated roots after attempted forceps removal?
  - What if the tooth is partially sectioned prior to extraction by trauma, malignancy, prior Tx, etc?

Ethical Moment

- How does one code (i.e. charge) when things don’t make sense?
  - 7210 Broken down endodontically treated molar. Can remove with elevator 5 min.
  - 7220 ST impaction with 1-2mm inflamed distal coronal tissue. Can remove in ≤5 sec.
  - 7240 CB impaction #1. Can remove in ≤60 sec.
    - Ref. Harvard coding development study

Ethical Professional Evaluation

- Codes represent points along the spectrum of 0-100% difficulty for Tx including care, skill, judgment, time, experience
  - How should one code if 99% of the way to the “next” code?
  - How should one code if 1% beyond the “last” code?

Anesthesia Fees, FYI

- Ongoing SDM chart review prompted an e-mail query about correlation between surgical and anesthesia times
  - I.E. why were anesthesia times found to be longer than surgical procedure times?
  - Answer: A. First the anesthesia, then the surgery. B. There is a difference between single-operator anesthetist anesthesia time and anesthesiologist time.
Operator-anesthetist

- "Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties." (2009-2010 ADA CDT)

Dedicated Anesthesiologist

- “Time for anesthesia procedures may be reported as is customary in the local area. Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision.” (ASA RVS)

DS conversations: scenario #1

- “I feel sorry for my patients and I want to give them a break, so I code all teeth 7140.”
- Guideline: OMS/ER Faculty are to code reasonably pre-op, accurately post-op
- Guideline: When one is in private practice, one can discount ad lib. At UNLV SDM, we have a fiduciary obligation to the public/taxpayers to code reasonably

DS conversations: scenario #1 addendum

- What is the incidence of chronic undercoding in dental school?
  - How many clinical three-surface restorations authorized as two surface restorations?
  - How many PC’ed whitening trays, etc?
- Is this a breach of SDM fiduciary duty to the public?

UNLV SDM Statistics

- Ancient Hx UNLV SDM: 90%+ coded 7140
- 2009 Hx UNLV SDM: 75% coded 7140
- Other SDM’s: 50-75% coded 7140
- OMS residencies: Can approach 0% 7140

DS conversations: scenario #2

- “Even though I took out 18 teeth, we didn’t treatment plan alveoloplasties since we didn’t think they’d be necessary.”
- Guideline: OMS (i.e. any doctor actually doing any dental procedure) will not treatment plan for operative, fixed, removable, etc. without consultation, but OMS would like the same courtesy.
DS conversations: scenario #3

- DS in OMS/ER: “We thought these were "simple," "easy," or "minor" procedures”
- Guideline: Teams are welcome to perform all "simple/easy/minor" procedures as they do not need specialist coverage
- Guideline 2 (Little League rule): Should health professionals opine about the difficulty of procedures they do not take responsibility for?

DS conversations: scenario #3, cont.

- Please define “simple.”
- The dictionary definition is convoluted but includes: “without complication.” Therefore anything that could reasonably result in a complication cannot be simple.
- P.S. Attorneys are particularly grateful for surgeons opining “simple” right before the case goes horribly wrong…

DS conversations: scenario #4

- DS from Team: “We have: inadequate LA, broken root, osseous fracture, OAF, infection, bleeding, AVM, paresthesia, etc. in Team; can an OMS come handle it?”
- OMS: “How did that happen?”
- DS: “We thought it was simple…”
- Guideline: See “simple” supra
- Question: If it’s simple, what do we need you for? Call a low-level provider…

DS conversations: scenario #5

- DS: “I’m not sure how to code this”
- Guideline: Neither is OMS faculty. Coding is ultimately determined during surgery (i.e. see the Orr inlay/onlay, 1978 NV SBDE exam)
- When reasonable doubt pre-operatively estimate high so SDM can offer a refund rather than be accused of bait and switch by unhappy patients

DS conversations: scenario #6

- DS: “It was easy/simple/minor”
- Guideline: See “simple” supra
- But, hypothetically, how long does a “simple” procedure take? Does one second removal of a child’s deciduous C equate to an hours/session-long 7140 procedure at the SDM?

DS conversations scenario #6 cont.

- A reason for the problem:
- Still:
Scenario #6: Hx last week

- Contrast to last week's UNLV SDM DS:
  - Tooth pre-op coded 7140
  - DS spent 30 min. with forceps and elevator without successful removal, consulted OMS
  - OMS recommended flap, bone removal pm, sectioning pm, and removal
  - DS proudly reported at 2+ hours tooth removed with forceps/elevator only, “saving patient $$$”
  - Duty to patient(s) fulfilled?

DS conversations: scenario #7

- “What if I don’t agree with Tx plan?”
- Guideline: Consider following ethical guidelines recommended for the real world and published by ADA and , i.e. call one’s colleague as an ethical professional would.

AAOMS CPC

- “…seek to achieve the highest level of ethical conduct in relations with patients, peers, and the public.”
- “…place the welfare of patients above all else…and to render help willingly to colleagues.”

CPC thoughts…

- Patients: Owed our highest duty
- Peers: If there is a concern, consult one on one with colleagues vs third parties (media, regulators, or others with COI)
- Public: The public was promised that the SDM would not require additional funding from taxpayers. The SDM should be ≥ fiscally neutral… contrary to popular belief, that is possible
  - Question: At present, is the SDM is breaching its promised fiduciary duty to the public?

ADEA: Professionalism, JDE July 2009

- Competence: “Model effective interactions with patients, colleagues, and students…”
- Fairness: “…provide balanced feedback to students, colleagues…”
- Respect: “Acknowledge and support the work and contribution of colleagues…”
- Service-Mindedness: “Model a sincere concern for students, patients, peers, and humanity in your interactions with all…”

TIME: Societal Trends…

- "Busybodies & Crybabies"
- What's happening to the American character?

12 August 1991
OT CPC, 1500 B.C.

- Exodus 20
  - V 16: “Thou shalt not bear false witness against thy neighbor”
  - 1500 B.C. Quote reported by Cousin Moses
  - Therefore: Be neighborly

KJV 1611

Malamed Sedation, 5th, July 2009

- “Any conduct that promotes frivolous legal action is only in the lawyers’ best interests, not in anyone else’s, including patients’. A health professional’s highest obligation is to patients, but that duty is part and parcel of other ethical obligations including those owed to one’s colleagues.”
  - Orr, DL, Legal Issues chapter 40

Finis: Emergency Instructions...

4. Be collegial
DENTAL SESSION V

SATURDAY, FEBRUARY 27, 10:00 AM - 11:40 AM

Brazos

MODERATOR:
Kalu Ogbureke, FRCPaH, FCLM, DDS, JD, DMSc, FDSRCS
Hired? Now What?  
The Office Policy Manual

Joseph P Graskemper DDS JD DABLM  
FAGD FAES FICOI FASO FACLM FACD  
Associate Clinical Professor  
Stony Brook School of Dental Medicine

- It is considered a legal document as to the rules of conduct for employer and employee.
- It gives notice to both regarding employment expectations and termination.
- Administrative Law Judges, Labor Department, and the Unemployment Benefits Office often turn to the office manual for guidance in their determinations and rulings for or against the employer.

- More than 50 employees have more regulations for written policies such as Family Medical Leave Policy, Healthcare Coverage.
- Also per state – workman’s compensation, equal opportunity employment, non-discrimination policies, military leave, accommodation for disabled, etc. may have to be in a written policy.
- A statement that this policy supersedes any and all previous written or stated policy
- Must have an acknowledgement page for employee to sign and date—do so with each update. Save the signed page in employee folder.

The Introduction
- Must be written clear and understandable
- Should have statement that the office policy manual is not an employment contract, express or implied.
- The office policy may be changed with or without notice by the employer. Employee will receive notice of such changes.
- Must be consistently enforced.
- You can have a mission statement and a vision statement which is helpful to new employees especially since it spells out the office “corporate culture”

Office Hours
- Current office hours are always subject to change per the employer
- Expected to arrive 15 minutes prior to scheduled time to prepare for patients. Arrivals prior to that 15 minutes will not be paid without prior consent.
- All employees are expected to leave ASAP after dismissal of all patients and completion of all duties.
- Time off during office hours and any overtime must have prior approval.
- Continued tardiness and/or absenteeism is grounds for termination. All employees must call in if tardy or absent.

Professional Responsibility in Dentistry
A Practical Guide to Law and Ethics
Joseph P. Graskemper

This book integrates dental law, risk management, professionalism, and ethics, as all are interrelated in everyday practice. True cases show real examples of professional and ethical issues facing the practicing dentist. Integrates various aspects of professionalism, ethics, law, and practice management. Written by a practicing dentist with a law degree. Offers perspectives on both the legal and dental aspects of ethical and professional questions.

Paperback | July 2011 | 220 pages | 978-0-470-95977-0 | $51.99

Order your copy today at wiley.com
General Office Rules

• State that the office is an “at-will” employer. The employer or the employee may terminate the employment relationship with or without cause and with or without notice. Hence, there is no employment contract or right.
• To be considered full time employee must work more than (30) hours. A part-time employee is anyone working less than (30).
• There are no benefits for part-time employees.
• All must follow infection control procedures.
• Gloves, mask, glasses must be worn whenever involved in patient care.
• There is a probationary period for all new employees of 90 days (which may be extended if needed and determined by the employer); after which is not a guarantee of employment nor implicitly promise any additional rights upon its completion.
• Any and all injuries occurring on the job must be reported immediately to the employer. All required forms must be properly filled out per OSHA compliance.
• This office prohibits harassment of an individual based on sex, race, religion, national origin, physical handicap or age. Any harassment must be immediately reported to the employer in confidence so an investigation may be done and corrective action taken.

Social Media

• Social media refers to Email, Facebook, Twitter, LinkedIn, blogs, and any other electronic communication or activity.
• Any electronic communication regarding the doctor/s, office, practice, and/or fellow employee is completely forbidden and cause for termination.
• If there is a problem, bring it to the immediate attention of the employer.

Paydays

• Paydays are on Thursdays and are based on your timecard.
• Time cards are property of the business.
• All notes regarding mistakes on timecard, sick days and vacation days must logged onto your timecard accordingly in order to be paid.
• Any adjustments will be made the following week.
• If payday falls on a holiday, vacation or when the office is closed, paychecks will be available before or after accordingly.

While employed and after termination all employees and former employees must adhere to HIPAA standards regarding patient information confidentiality and are prohibited from any direct or indirect solicitation of other employees and patients and/or making any disparaging remarks of the employer, employees or patients on or within any electronic communication.
• No overtime will be paid without prior approval of the employer.
• Everyone is expected to work as scheduled. Overtime is only paid after 40 hours per week.
• Paychecks, wages, bonuses, level of pay or any other remuneration or gifts are strictly confidential. Any communication regarding such information is cause for dismissal/termination.
• Employees will be evaluated approximately yearly on their anniversary hire date. This is not a guarantee of wage increase or bonus or continued employment.
• Raises in pay are based on merit only and only at the discretion of the employer.

Paid Holidays
• Employees must be full-time for 90 days (introductory/probation period) to be eligible for a paid holiday.
• Holidays are as follows:
  - New Year’s Day
  - Memorial Day
  - Independence Day
  - Labor Day
  - Thanksgiving Day
  - Christmas Day

When a holiday falls on a vacation day, you will be paid for that day. You will not be paid double for that day and will not take another day off in place of the holiday.

Jobs
• Business Manager
• Office Manager
• Administrative Assistant
• Treatment Coordinator
• Appointment Scheduler
• Communication Coordinator
• Insurance Coordinator
• Dental Assistant
• Dental Hygienist

Job Duties
• Front Office – phones, appointments, insurance, recall, etc.
  • Daily
    - Turn off all switches
    - Turn off printers, calculator
    - Close down all computers, turn off monitors
    - Turn lamp on
    - Set back up
    - Set alarm

  • Weekly
    - Water plants
    - Clean counters and machines
    - Organize front reception area including magazines as needed
    - Vacuum and mop floors, and clean restroom
**Back Office**

- **Daily** – Greet pts., set up and take down rooms., ordering, etc
  - Clean, Scrub all instruments, including the handpiece heads
  - Mark down needed supplies, temp. crowns
  - Oil all slow speed handpieces
  - Close down all computers, turn off monitor
  - Turn off x-ray developer
  - Turn off all switches
  - Set alarm
  - Change cold sterilizer, ultrasonic solution, rag wheels, or as needed

- **Weekly (or more often if needed)**
  - Organize treatment trays, rct files, drawers, cabinets
  - Wipe down all counters cabinets, change papers in drawers as needed, change towels
  - Wipe down equipment, x-ray heads, chairs or after each use
  - Vacuum, mop floors in all operatories and lab area if needed
  - Clean traps and central trap

- **Clean and autoclave lab handpiece, burs and wheels as needed**
- **Every week send in autoclave monitor**

- **Monthly**
  - Every 3 months clean autoclave or as needed
  - Check pumice, stone and plaster trays

- **Employees are to furnish their own uniforms clean and pressed (scrubs of proper color, shoes)**
- **There will be no unprofessional footwear**
- **Chair side jacket (infection control barrier) are made available for those involved in patient care**
- **A yearly uniform allowance may be given**

**Personal Grooming**

- Hands and fingernails should always be neatly trimmed and clean
- Work clothing (scrubs) should always be clean and pressed
- Hair should be neat and clean at all times and not interfere with office duties or patient care. Long hair should be pulled back.
- All makeup application should be done in the restroom, not within patient view, and on your own time.
- Oral hygiene after any meals and daily showers and deodorant is a must.

**Uniforms**

- Hands and fingernails should always be neatly trimmed and clean
- Work clothing (scrubs) should always be clean and pressed
- Hair should be neat and clean at all times and not interfere with office duties or patient care. Long hair should be pulled back.
- All makeup application should be done in the restroom, not within patient view, and on your own time.
- Oral hygiene after any meals and daily showers and deodorant is a must.

**Oral Hygiene**

- All members of office team should seek regular dental care and cleanings
- Practice what you preach!!
Staff Meetings

- Staff meetings are held monthly or as determined by the employer
- Staff meetings are mandatory (excused absences are allowed)
- They are for the benefit of all and allows for proper communication to improve patient care.
- It is NOT a grip session.
- An anonymous suggestion box is available. All appropriate suggestions will be covered at the staff meeting or may be brought to the attention of the employer at any time.

Employee Relationships

- Employees are encouraged to cooperate with one another for the good of the practice. “Team Work” and helping one another is essential; even if it means going beyond your normal daily duties.
- Any and all intra-office problems must be immediately brought to the attention of the employer.
- Bickering and arguing between employees or with the employer will be grounds for dismissal/termination.
- Keep communications open and positive.

Continuing Education

- Should you attend a continuing education course, you will not be paid for time away from the office (check with state).
- Any payment for cont. educ. is at the discretion of the employer.

Employee Breaks

- Breaks are not to be taken at the expense of the patients’ care or if interrupting front office duties. Breaks are to be taken when and if there is a break between patients.
- Taking breaks in excessive numbers or length or if it interferes with patient care are grounds for dismissal/termination.

Office Supplies

- Stamps, light bulbs, toilet tissue, facial tissue, dental supplies are all part of the business. Pilferage will be cause for dismissal/termination. This includes pens, pencils, and office supplies.

Phone Calls

Office and Cell Phones

- The office phones are for office business. Personal use of business phones is limited to essential communication or in the case of an emergency.
- Excessive phone calls (incoming and outgoing) for personal use is cause for termination.
- Personal phones will not be received at work except in the case of an emergency. A message will be taken so you may return the phone call on your own time, not office time.
- Personal cell phones MUST be on silent mode or off.
• Employees are prohibited from using cell phone cameras or video recorders on the premises of the practice

• All patients are to be greeted by name and with a smile to establish identity.
• Address patients by Mr., Mrs., Miss, Ms., or Dr. when appropriate; normally if older than you. First names of older patients are only allowed with the patient’s permission.
• Patients are not to be talked about in front of other people (HIPAA, Dr-Pt Confidentiality, Pt. Autonomy)
• Any improper and/or discourteous attitudes towards any patient will not be tolerated and will be grounds for dismissal/termination.
• There should be no dating of patients that were not previously known to you.

• There is no medical insurance through the office
• Medical insurance is personally available through the NYS Health Insurance Marketplace

• No benefits are available prior to 90 days of employment
• During the first year all dental benefits are at the discretion of the employer
• After 1 year of full time employment, 50% off regular UCR fees plus any lab fees incurred. Routine prophys, x-rays, and exams are at no charge if the employee clocks out.
• If the employee has dental insurance outside of the office, the ins. co. will be billed and any payments will be applied to the employee’s balance.

• All dental care to be done during slow hours, on employee’s time and with employer’s knowledge
• All appointments to be made with consideration of the scheduling of regular patient
• Employee’s time card must be properly marked for time taken off for dental care.
• Spouses and children are given a 50% off regular UCR fees plus any lab costs.
• Any cancellation fees will be applied to all family members
• There will absolutely be no refund of insurance payments to employee or their families.

• Other family members include the employee’s mother, father, brothers and sisters. They will be given a 20% courtesy off regular UCR fees. No other relatives are included.
• Any balance due for dental services for employee, spouse, children or other family members will be taken out of the employee’s last paycheck upon termination
• There are no dental benefits for part-time employees. Any courtesy is at the discretion of the employer
• All insurance forms must be filled out with assignment of payment to the office
Vacations
- There will be no paid vacations for the 1st year of full employment.
- All vacations days should be taken when office is closed.
- All vacations days will be taken prior to any approved personal days, which are without pay.
- All vacation/personal days must be approved at least 2 weeks in advance.
- Paid vacations are for full-time employees only.
  There is no paid vacation for part-time employees.
- Using sick days for any other use is cause for termination and will not be paid.

Sick Leave
- After 2 years employment full-time employees will be eligible for 1 week paid sick leave (as broken down by the number of half-days worked).
- If and when sick, the employer must be informed before the start of work on the day you are missing due to sickness. Failure to do so is cause for dismissal/termination.
- Sick days are only used if you are too sick to come to work.
- Using sick days for any other use is cause for termination and will not be paid.

Other Benefits
- Bonus
- Pension
- Cont. Educ.
- Life ins.
- Day Care
- Maternity Leave
All employees agree that any and all patient charts, files, and lists shall belong to and are the sole and exclusive property of the practice and the employer. All employees further agree and acknowledge that the patient charts, files and lists and the information contained therein and the names and addresses of all patients are confidential and constitute trade secrets of the employer. All employees further promise and agree that he or she will not disclose and such confidential information, including office policy and office management information and procedures to any other person and shall not use such confidential information other than in the connection with the employment for the practice and the employer.

During employment, after termination and thereafter, Employee agrees to take no action (written or oral) which is intended, or would reasonably be expected, to harm [Dentist/Dental Office/Fellow Employee] its/their reputation or which would reasonably be expected to lead to unwanted or unfavorable publicity to the [Dentist/Dental Office/Fellow Employee].

This policy may be reviewed by the employer and changes may be made without notice based on the sole discretion of the employer. No statement of policy as set forth in this policy manual is intended as a contractual commitment or obligation of the employer or the office or any individual employee or group of employees. Circumstances may arise in which the employer determines that changes in these policies are required. For this reason, the employer reserves the right, at any time, to modify, rescind, or supplement any or all action which may be contrary to a policy set forth herein with notice to employees.
DENTAL SESSION VI

SATURDAY, FEBRUARY 27, 1:15 PM - 3:00 PM

Brazos

MODERATOR:
Chester Gary, DDS, JD, FCLM
FAILURE TO DIAGNOSE ORAL CANCER AND OTHER PATHOLOGIC CONDITIONS OF THE ORAL CAVITY

Kalu U.E. Ogbureke, BDS, MSc, DMSc, JD, FDSRCS, FDSRCPs, FDSRCEd, FRCPath
Diplomate, American Board of Oral and Maxillofacial Pathology (ABOMP)
Diplomate, American Board of Medical Malpractice (ABMM)
Fellow, American College of Legal Medicine
Fulbright Alumnus (Scholar, University of Lagos, 2010-2011)

Fear of being sued as a physician/dentist is real, although putting this "fear" in context is helpful!

RESULT OF SURVEY OF 1705 LAWSUITS*


<table>
<thead>
<tr>
<th>Disposition of Suit</th>
<th>Number (%) of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dropped by Plaintiff</td>
<td>513 (30)</td>
</tr>
<tr>
<td>Settled Out of Court</td>
<td>460 (27)</td>
</tr>
<tr>
<td>Suit Pending</td>
<td>260 (15)</td>
</tr>
<tr>
<td>Jury Verdict for Physician</td>
<td>182 (11)</td>
</tr>
<tr>
<td>Dismissed by Judge</td>
<td>171 (10)</td>
</tr>
<tr>
<td>Resolved by Arbitration and Mediation</td>
<td>66 (4)</td>
</tr>
<tr>
<td>Jury Verdict Against Physician</td>
<td>53 (3)</td>
</tr>
</tbody>
</table>

Conclusion: Majority of lawsuit threats do not materialize, and the majority of those that do are decided in favor of the physician.

ORAL CANCER: A significant Public Health Concern

- Over 90% are oral squamous cell carcinoma (OSCC)
- About 33,000 new cases in the U.S. annually
- Represents 5% (m=3; f=2) of all malignancies in the U.S.
- Survival rate essentially unchanged over three decades: 50%
- Early treatment 5YSR = 80%
- Up to 50% mortality in advanced cases
- Recurrent disease may signal non-curability


ORAL CANCER: Other Epidemiologic Facts

- Individuals 45 years of age and over – 90 percent
- Tongue cancer increasing in males <40 years old
- 14th most common cancer among all U.S. females
- Male to female ratio has decreased from 6:1 in 1950 to 1.8:1
- Incidence in women has increased from 15% to 33% of all cancers diagnosed in last 45 years

- Occur more frequently in African-Americans than Caucasians
  - 4th most common cancer in African-American males
- Oral cancer mortality rates are also high for African-Americans
  - Nearly twice the mortality rate of Caucasians in 1998.
  - Oral cancer is the 7th leading cause of cancer death in African American men
## Etiologic Agents
- Tobacco products
- Alcohol
- Viruses (Particularly HPV)
- Others

## The Oral Cavity
“The Oral Cavity is one of very few body sites conducive to visual inspection thereby offering morphological features detectable as precancerous changes that provide opportunity for early detection and intervention.”

*Oral cavity is easily accessible for routine clinical examination*

## Oral Cancer: Missed Diagnosis; Misdiagnosis
- The incidence of missed diagnosis and misdiagnosis relatively high compared to cancers of other regions of the GI tract
  - Diagnosis of Oral Premalignant Lesions (OPL) still present challenges
- Non-standardized and archaic paradigm still in use for clinical diagnosis

## Missed Diagnosis: Premalignant Lesion (precancer)
**Lesions with higher than normal propensity for transition to cancers with time, in the absence of adequate intervention**

## Oral Premalignant Lesions (OPL): Misdiagnosis?
- *Leukoplakia*
- *Speckled Leukoplakia*

*Clinical terms implying no specific histopathology and therefore of no pathological diagnostic value*

## Misdiagnosis/Underdiagnosis/delayed diagnosis
**Erythroplakia**: a red patch/plaque not attributable to any known etiology/diagnostic entity.

*Could be mistaken for inflammatory cause (e.g. trauma) leading to delayed diagnosis*
ORAL CANCER: Who is at risk for malpractice litigation?

- Dentists: all specialties
  - Failure to diagnose
- Oral and Maxillofacial Surgeon
  - Misdiagnosis/Mismanaged
- ENT
  - Misdiagnosis/Mismanaged
- Oral and Maxillofacial Pathologist
  - Misdiagnosis/Failure to Diagnose

SPECIALTIES

Cancer of the Oral Cavity and Medical Malpractice.

<table>
<thead>
<tr>
<th>TABLE III.</th>
<th>Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>1/47 (2%)</td>
</tr>
<tr>
<td>Dentist (DS)</td>
<td>17/47 (37%)</td>
</tr>
<tr>
<td>Oral surgeon (OS)</td>
<td>4/47 (9%)</td>
</tr>
<tr>
<td>Total dentist</td>
<td>21/47 (45%)</td>
</tr>
<tr>
<td>Otolaryngologist (ENT)</td>
<td>8/47 (17%)</td>
</tr>
</tbody>
</table>

Subgroup Analysis.

Common Perspectives for Law Suits

- Oncologic outcomes
- Patients Age

Subgroup Analysis: GP = general practice; DS/OS = dentist/oral surgeon; ENT/HNS = otolaryngologist/head and neck surgeon.
COMMON PERSPECTIVES FOR LAW SUITS: Oncologic outcome

<table>
<thead>
<tr>
<th>Table 1. Findings When Comparing Suits From the Perspective of Oncologic Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dead</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>50</td>
</tr>
<tr>
<td>Failure to diagnose</td>
</tr>
<tr>
<td>Failure to biopsy</td>
</tr>
<tr>
<td>Failure to refer</td>
</tr>
<tr>
<td>Surgical complication</td>
</tr>
<tr>
<td>Delay in ref (mo)</td>
</tr>
<tr>
<td>Defendant verdict</td>
</tr>
<tr>
<td>Settlement</td>
</tr>
<tr>
<td>Plaintiff verdict</td>
</tr>
<tr>
<td>Average Award (mil)</td>
</tr>
<tr>
<td>NED - no evidence of disease</td>
</tr>
</tbody>
</table>

COMMON PERSPECTIVES FOR LAW SUITS: Plaintiff Age

<table>
<thead>
<tr>
<th>Table 2. Findings or Comparision Based on Plaintiff Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group A</td>
</tr>
<tr>
<td>Oncologic outcome</td>
</tr>
<tr>
<td>Defendent</td>
</tr>
<tr>
<td>Dismissed</td>
</tr>
<tr>
<td>Awards</td>
</tr>
<tr>
<td>5 year(s) $1 million</td>
</tr>
<tr>
<td>10 year(s)</td>
</tr>
<tr>
<td>Pending approval in U.S.</td>
</tr>
</tbody>
</table>

DIAGNOSTIC ADJUNCTS:

- **Toluidine Blue**
  - Fast and easy office procedure
  - Stain suspected malignant tissue
    - When several surface abnormalities are present
  - Tissue that stains blue indicates either dysplasia or malignancy
  - Pending approval in U.S.

- **Chemiluminescent Light**
  - A liquid similar to diluted vinegar is applied to the area of the mouth to be screened
  - Under the special light, the liquid causes pre-cancerous or cancerous cells to glow
  - Approved for use in the United States but not yet widely available

- **“Brush’ Biopsy (smear cytology)**
  - Uses small stiff-bristled brush to collect mucosal epithelial cells from a suspicious site
    - Apply firm pressure with the brush to the suspected area
    - Brush is then rotated five to ten times until pinpoint bleeding occurs
  - Immediately place and fix the tissue on a slide
  - Slide is subsequently sent to a laboratory for computer analysis
    - Results sent back to the practitioner within a week
DIAGNOSTIC ADJUNCTS: Biopsy

- “Gold Standard”
- Provides most definitive diagnosis
  - If malignant, determines the stage and grade
- Common oral biopsy techniques:
  - Excisional
    - Remove whole lump
  - Incisional
    - Remove a portion of the lump
  - Punch
    - 3-4mm diameter – cuts out cylindrical piece of tissue

ORAL CANCER EXAMINATION

- Can be performed by:
  - Dentist
  - Dental Hygienist
  - Physician
  - Physician’s Assistant
  - Family Nurse Practitioner
  - Nurse

In malpractice lawsuits, Respondeat Superior ("Master-Servant Rule") may apply.

MISDIAGNOSIS/UNDERDIAGNOSIS OF ORAL CANCER: Summary/Conclusion

- Litigation in patients with oral cancer is relatively rare
- Young patients more likely to pursue litigation than their old counterparts
- Patients who sue often have poor oncological outcomes
- In order to prevent subsequent litigation, guidelines and risk management goals must aim to prevent delays in diagnosis.

Good Morning
And
Thank you All for Listening

OTHER LESIONS: Child Abuse Cases
SEXUAL ABUSE:
Forced Fellatio

SEXUAL ABUSE:
Orogenital Contact

Condyloma Accuminatum
- A sexually transmitted disease resulting from Orogenital contact

CASE REPORT

A 7 year-old female with broad and papillary mandibular gingival lesion
**Diagnosis:**
Viral Papilloma, morphologically consistent with Condyloma Acuminatum.

Patient (Child) should be evaluated with that in mind.

---

**INTERVENTION**

As a Professional, You **Must** Report!!!!

For Healthcare Professionals, Oral Report within 24 Hours

---

**INTERVENTION (2)**

- Referral
  - Child Protective Services
  - Adult Protective Services

1-800 252-5400
800 25-25 400

---

**Good Morning**
**And**
**Thank you All Again for Listening**

??????