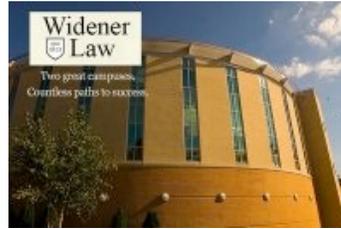


# HEALTH LAW COLLOQUIUM

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WIDENER UNIVERSITY SCHOOL OF LAW  
HEALTH LAW SOCIETY



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## HEALTH LAW SOCIETY

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The Health Law Society (HLS) is an interdisciplinary organization of students, faculty and alumni dedicated to exploring the career opportunities and current issues in health law. The Society strives to explore the range of possibilities in health law from beyond the traditional practice area of medical malpractice to managed and long-term care, bioethics, corporate issues, and health care reform. We also participate in health-related public service activities benefiting the community throughout the tri-state area. HLS draws on the diverse resources available at Widener - students, faculty, and alumni - to build a greater understanding of health law practice.

## MESSAGE FROM THE PRESIDENT

My name is Kristopher Kachline and I am the President of the Health Law Society. In this time of great change, I feel fortunate to be part of the solution. The people who will make the greatest difference in the health care debate are those willing to read and write about it. People who have an idea, an opinion, should let it be heard. The purpose of our Colloquium is to allow students here at Widener voice their opinion, express their ideas, or simply read what others are thinking in the quest to find their own stance on tough issues. I hope that you, the readers, find that this issue supports your own view, or challenges what you thought you knew and brings a new view to light.

This next year will hopefully bring more change to our system of health care than ever before. I challenge everyone to be open-minded, as there is no one way to mend our broken system. If reforms are to be lasting, they will have to be the ultimate example of give and take. Hopefully we are willing and ready.

-Kristopher Kachline

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*The people who will make the greatest difference in the health care debate are those willing to read and write about it.*

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## FIGHTING AIDS AND ABBOTT LABORATORIES: THE ANTITRUST SUIT THAT IS A “WIN” FOR THE HIV/AIDS COMMUNITY

BY JUSTIN SCHLUTH

HIV/AIDS is an epidemic that currently affects over 33,000,000 people worldwide. Worse yet, this number continues to rise, as it has done for the last twenty years. Although no cure exists for HIV/AIDS, there are several drugs that can slow the progress of the disease. One such drug, Norvir, is a protease inhibitor that boosts efficiency of other antiviral drugs. Norvir was developed by Abbott Laboratories in 1996 using a federal grant of over \$3,000,000. Although it was initially released as a standalone antiviral drug, it now is primarily used to boost the efficiency of other drugs. This boost in efficiency means that HIV/AIDS patients can take smaller doses of their antiviral drug coupled with Norvir to decrease the side effects of antiviral drugs. Ultimately, Norvir helps patients to live more comfortably. Or does it...?

In 2000 Abbott Laboratories released a drug called Kaletra. Kaletra is an antiviral drug that is synthesized with a dose of Norvir. The result was that now patients who usually took two pills, only had to take one Kaletra. Kaletra, though, did not seem to be the drug of choice for most patients. Patients reported side effects that were less tolerable resulting from Kaletra compared to other antiviral drugs paired with Norvir. Abbot Laboratories responded in 2003 by raising the price of Norvir from \$1.71 to \$8.57 per day. Kaletra, which has Norvir in it, remained the same price. The 500% price hike forced many patients to switch to the now less expensive Kaletra, and to its' less desirable side effects.



In 2004, Service Employees International Union Health and Welfare Fund (the “Fund”) brought suit against Abbott Laboratories claiming that this price hike was a violation of federal antitrust laws. The Fund claims that the spike in the price of Norvir by Abbott Laboratories was a scheme to make Kaletra the preferred drug. By increasing the price of Norvir over five-hundred percent, other drugs that need Norvir to boost efficiency became too costly when compared to Kaletra’s price, which remained constant. According to the Fund, other antiviral drugs could not compete with the low cost of Kaletra, and the price hike had effectively caused a monopoly. Abbott Laboratories responded that the increased price of Norvir is a result of the drug’s enormous clinical value.

Abbot Laboratories moved to dismiss the case but was unsuccessful. Abbott Laboratories then filed a summary judgment motion arguing that they owned a patent on using Norvir as an antiviral drug booster and that it could legally prevent patients from using Norvir with antiviral drugs from other companies. The Fund asked the court to dismiss this argument and to send the case to a jury. The United States District Court in the Northern District of California dismissed the summary judgment motion holding that Abbott Laboratories could not encourage consumers to take Norvir to boost antiviral drug efficiency and simultaneously claim that patients were violating Abbott Laboratories’ patent rights. The result was that the case was certified for class action. Eventually the Ninth Circuit Court of Appeals approved a settlement agreement that required Abbott Laboratories to pay \$10,000,000 to nonprofit organizations that served individuals with HIV. It is being deemed a loss for the individuals that have to pay the price hike and suffer the side effects, but a win for the HIV/AIDS community.

## HOW FAR IS TOO FAR FOR COURTS?

BY MITCH PALAZZO

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*A Texas woman was ordered by the court not to have children during her 10-year probation sentence.*

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When studying the law, from constitutional law to torts, the question always arises as to how far the law can go when infringing on the rights the people it protects. Social contract advocates will demand that the members of any nation state must forfeit certain privileges in order to establish a functioning society. Human rights protestors counter that the individual has the right to govern their own life, as long as it does not adversely affect the lives of others. In a society which has recently as the 1960's upheld laws against same-race marriage, still widely prohibits same-sex marriage and denies convicted felons the rights to vote, the debate goes on and touches all aspects of the law.

This includes health law. Last month a Texas woman, who failed to provide protection and health care to her abused daughter, was ordered by the court not to have children during her 10-year probation sentence. Texas law states that that a judge can impose any probation condition as long as it is reasonable. In this case the judge felt this condition a reasonable means to ensure that the woman understands the responsibility to having a child. It is also important to not that the woman in question was 19 at the time and would have to opportunity to bear children again after her probation expired.

A similar decision was reached in a 2001 Wisconsin case where a man convicted of failure to pay child support was ordered not to father any children until he proved he could provide for them. Regardless of the whether these types of restrictions can be enforced, the question of how far the law can go to protect its citizens appears again. And once again advocates appear for both sides.

Those in favor of this type of intrusion argue that a primary function of government, and its court system, is to protect its citizens. This role of protection increases in the case of children that cannot protect themselves. Evidence supporting this stance might be in abuse cases themselves. Where a parent cannot take care of child or protect that child from harm, the government must provide that shield for them. Those opposed contend that this type of punishment undermines Supreme Court rulings that have enhanced individual's rights. In this particular case human rights activist shout that a condition prohibiting a woman from having children violates her right to reproductive freedom.

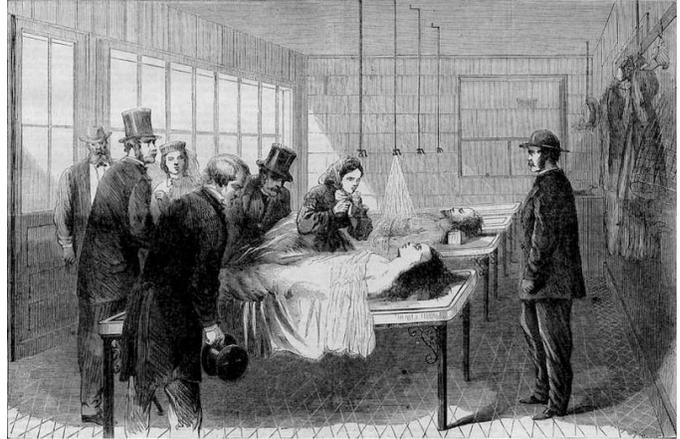
Perhaps the prosecuting attorney in the Texas case, Allison Wetzel, stated the issue best. She noted that many people who read the case will feel that those who abuse children, or allow the abuse to occur, do not deserve to have them, but that the court should not necessarily make that judgment. However in this case, and similar ones, a judgment does have to be made. As U.S. society continues to change, its mores and expectations will also adjust. Yet the question of how far the legislature and court system should modify laws is one that remains to be answered.

## Who Owns the Human Body?

By Brandon Zanan

An autopsy includes, by definition, the removal and sometimes the retention of specimens from the human body. Having served as an intern in the Montgomery County Coroners Office for six years under the late Halbert ("Homicide Hal") Fillinger, I have learned that in most states, medical examiners and coroners remove brains, organs and tissues during autopsies for examination later in a laboratory. Medical examiners and coroners will usually inform families in general terms about what occurs during the autopsy. However, I learned, they do not usually explain to families exactly what an autopsy entails, nor do they inform families that certain specimens may be retained during the autopsy or contact the family afterward to find out how they would like to dispose of whatever specimens were retained.

During my internship, I was asked to follow a case that was filed in Ohio. Thirty-year-old Christopher Albrecht drowned in December 2001. His vehicle ran off the road and landed upside down in a retention pond. Albrecht's parents understood that an autopsy would have to be performed on the body of their son. Five years after the autopsy had been performed, the Albrechts saw for the first time a copy of the autopsy report. It was then that they realized that not all of Christopher had been buried. The coroner's office had removed their son's brain for forensic examination and had retained it after the autopsy. At the time Christopher was buried, his brain was in Cincinnati still waiting further examination to determine the cause of death. The coroner's office never informed the Albrechts that their son's brain had been retained. The Albrechts were shocked to discover that they had unknowingly buried their son without his brain, which was later disposed as medical waste.



The Albrechts did not question the coroner's right to perform an autopsy as required by Ohio law, or the authority of the coroner to remove tissues, organs or specimens to determine the cause of death. The Albrechts alleged that once the autopsy was completed, they should have been given the opportunity to retrieve the brain for burial, and that the defendants' failure to give them that opportunity violated their due process rights. They claimed that the coroner's policy of not giving them any notice regarding the retention and disposal of their decedent's brain deprived them of their property interest in their decedent's remains without due process of law.

The Albrechts filed an action against the county coroner, the Board of County Commissioners and others, seeking damages arising out of the coroner's failure to inform them that he was retaining their son's brain as part of the autopsy, and failure to return the brain to them when the autopsy was concluded. They alleged that they were denied due process of law when the coroner "took" parts of their son's body. The action was later made a putative class action against county coroners and medical examiners in all but one of Ohio's counties.

Filed in federal court in Cincinnati, Ohio, the United States District Court for the Southern District of Ohio in *Albrecht v. Treon*, No. 1:06CV274 (S. D. Ohio, 2007), declared that the fundamental question is whether the relatives of a decedent had the legally cognizable interest under Ohio law, protected by the 14th Amendment, in being notified by the county coroner that the coroner has removed and retained body parts of the decedent for forensic examination while returning the rest of the body to the family. Rather than address this issue head-on, the District Court decided to certify the issue to the Supreme Court of Ohio.

In *Albrecht v. Treon*, 118 Ohio St.3d 348, 889 N.E.2d 120 (Ohio 2008), a majority of the court addressed the issue from a purely due process of law and property interest perspective. The majority began its analysis by noting that this case involves "the balancing of delicate issues involving a family's right to properly bury their deceased loved one in a condition that is as complete as possible against the state's right to conduct an autopsy where appropriate in a thorough and timely manner." The majority then declared: "We... hold that the next of kin of a decedent upon whom an autopsy has been performed *do not have a protected right* under Ohio law in the decedent's tissues, organs, blood, or other body parts that had been removed been retained by the coroner for forensic examination and testing." [Emphasis added.]

The court declared that it was mindful of the right of a decedent's next of kin to attend to the proper preparation and burial or cremation of the body. "But nothing in the United States Constitution, the Ohio Constitution, Ohio statutes or common-law establish a protected right in autopsy specimens in Ohio. ... If the General assembly believes that next of kin should have a right to autopsy specimens when the coroner's office is through with them, it should provide that right by statute. The issue of whether notice is required, what notice is required, and whether and under what circumstances tissue and organs can be removed and retained during the course of an autopsy are issues for the Legislature, not the courts."

In a strongly worded Dissenting Opinion, Judge Pfeifer approached the issue not from a strictly due process and property interest viewpoint, but from a more expansive bioethics perspective, and emphasized the proper disposition of a deceased's body. "In the end, this case is not about a random piece of human tissue. It is about the decedent's brain. A brain is not a fingernail. The brain was the source of the deceased's every thought, aspiration, dream, fear, laugh, memory, or emotion; it was the origin of every word spoken, every song sung, every joke told; everything a family member loved about the deceased could be traced back to it. If the next of kin have any right to the decedent's body, the right must include the brain."

Judge Pfeifer concluded: "According to the majority, this case turns on the idea of property rights. But in truth, the point of the plaintiffs-respondents, and a point that has been recognized in Ohio law, is that a deceased's remains are not mere property. They are on a higher plane. The law does not require respect or reference for property, but the law does require that in the treatment of the dead. ... It should not be disposed of for the sake of convenience."

This litigation in Ohio has drawn attention and concern in the Montgomery County Coroner's office, as well as among coroners and medical examiners nationwide. See Hansen. "*The Body in Question: Coroners Eye Ohio Suit Demanding They Tell Families About Removal of Body Parts*," 93 American Bar Association Journal 23 (July 2007). Should this case proceed further, it could potentially change the way autopsies are conducted in the United States, and may also affect other aspects of the medical profession, such as when surgeons remove organs and body tissue during surgery. It is quite possible that this case will eventually make its way before the United States Supreme Court.

## Beveridge Versus Bismarck: Health Care Systems in Europe

By Jeffrey Goldin



Assuming everyone has been listening to the news, we are all aware of the Obama administration's plan to reform health care. The current health care system in the United States is actually ranked low compared to many other countries. With all this new health care reform commotion, it is appropriate to try to understand other health care options available to us, or at least that are used in the world. That being said, the right to health care is internationally recognized. Every nation has adopted some form of a public health care system which provides health care coverage for the citizens of that nation. Though many nations still have a private market for health care, including the United States, a portion of their populations are ensured to have public health care coverage. There are several varieties of approaches as to how this public health care system can be delivered. As endless as these approaches may seem, there are still common approaches to health care distribution that are used throughout the world. To better understand the importance of health law in the world, it is imperative to know what context this health law exists in. Therefore, it is important to know the different systems by which health care is distributed.

The World Health Organization (“WHO”) ranked world health care systems in their World Health Report 2000. The Report ranks these health care systems through three variables: contribution to improvement of health status, fairness in distribution of health care resources and costs, and responsiveness to expectations in regard to non-health matters such as dignity, autonomy, and confidentiality. Based on these variables the United States ranked 37, mainly due to the lack of fairness in their distribution and costs. France, however, ranked first in overall performance. To better understand how these rankings came to be, it is important to understand how certain health care systems came to be.

It was not until the late 19th century that many European governments focused on the health of their citizens, particularly due to deaths relating to mosquito-transferred disease and various infectious diseases that arose from development exposure. The increasing death tolls led to decreases in work productivity which led to companies providing health coverage for their workers. Worker's health had become a major political issue in Europe. The first to address this issue was Otto von Bismarck, the Chancellor of Germany. Concerned that the socialist workers' movement was gaining strength, Bismarck felt it fit to have a government take over of labor union sickness funds. Thus, in 1883, Bismarck created the first state-mandated social insurance policy. This policy required employer contributions to health coverage for low-wage workers. The success and popularity of this system led to similar systems developing in Belgium in 1894 and in Norway in 1909. The influence of this German model spread after World War I. In 1922, Japan adapted a similar health care system adding benefits to the already existing benefits workers were eligible for. In 1924, Chile's Ministry of Labour umbrellaed all medically covered workers. German occupation in World War II introduced this system to the Netherlands and by 1935, 90% of Denmark was covered by work-related health insurance.

World War II practically destroyed several nations' health care systems. Britain created a wartime emergency service to deal with casualties. This was the first sign of Britain's national health care service. The Beveridge Report of 1942 identified health care as a prerequisite to a viable social security system. In 1944 the government's White Paper created a policy stating, “Everybody, irrespective of means, age, sex or occupation shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available.” It also added that these services should be free of charge and promote good health. Prior to this document, New Zealand had already created the first national health care service in 1938. Followed by Costa Rica in 1941 and Mexico's creation of a Institute of Social Security and Ministry of Health in 1943. In addition, after World War II, Japan and the Soviet Union extended their limited national health care coverage to cover almost all the population, as well as Hungary, Sweden, Norway, Chile, and other communist states in Europe.

Today's modern health care models are loosely based on the models created in the late 19<sup>th</sup> century and early 20<sup>th</sup> century. The major aim of these modern models is to cover most citizens through mandated

employer and employee payments into insurance funds. The two major systems that the modern systems adapted from these previously created models are social insurance and national insurance.

Based on the German system created in the 1883, and duly recognized as the Bismarck system citizens have an obligation to secure health insurance coverage. This coverage is generally funded through deductions from employee earnings on the basis of the individual's income rather than health risk. Those whose salaries fall under a certain number must be part of this social insurance system. This social obligation is a concept known as "solidarity" which is a belief that members of a society have an obligation to other members of that society rather than just themselves. In order to fund this type of insurance system, employers and employees must each contribute a portion of wages to social insurance funds. These funds in turn provide coverage for the employees and their families. These funds are administered by non-profit organizations, most of which are specific to their members. For example, Bavarian Motor Works (BMW) is insured through a company fund, whereas farmers are covered through special funds. All funds provide similar coverage and charge relatively similar premiums. Though countries such as France and Austria are considered to be social insurance model systems, they have programs that cover the entire population as well.

As mentioned earlier, post World War II United Kingdom established health care as a basic right of its citizens. This national health care system exists independently from the economic or employment status of the individual. England's National Health Care Service (NHS) is funded through general revenue tax rather than through employee wages. These funds purchase services from hospitals, general practitioners, as well as private businessmen and provide them to the general public, mostly without costs.

Many nations have adopted this type of national insurance system. Canada, Australia, the Scandinavian countries, Spain and some Latin American and Asian countries are just a few that currently have a national health service. The United States "Medicaid" service even similarly resembles a national insurance system. Though these nations provide a public health care system most of them have a sort of private health care market. Germany, for example, has a private system which covers the wealthy who are not covered by the social insurance. And in the United Kingdom those who are privately insured can get services faster than those who are publicly insured. In many southern European nations, many people choose to have private insurance even though national insurance exists because they believe it will give them better service.

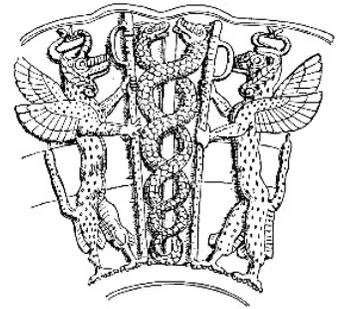
Though public finance of health care is common in most countries, the provision of these health services are commonly private. For example, Pharmaceuticals are produced by private companies and though in most national health care countries, public hospitals dominate, private hospitals also exist. In fact, they are even more common in social insurance countries.

All in all most nations recognize health care as something their citizens are entitled to possess. Be it given to every citizen and funded by taxes or funded through income and given to many citizens in a certain income range, the general idea is that equal health coverage should be available to all citizens.

## Conditional Res Ipsa Loquitur Instructions: Delaware's Powerful New Tool in Medical Negligence and Medical Products Liability Cases

By James Meehan

Often times, a medical malpractice plaintiff's attorney must decide whether to sue the surgeon or the medical product manufacturer. Discovery can ascertain whether a doctor's negligence or a faulty medical product is to blame. Unfortunately the memories of doctors and nurses are often not reliable enough to determine with any reasonable certainty that it was one rather than the other. Was the needle packaged correctly? Was the needle taken out of its packaging correctly? A "no" answer to either question would result in two different defendants. Delaware plaintiffs no longer have to make this tough decision thanks to the ruling in Moore v. Anesthesia Services, P.A., 966 A.2d 830 (Del.Super. 2008).



Moore was admitted for carotid endarterectomy surgery. This procedure requires a thin 6-0 suture. The surgery appeared to have gone successfully until Moore became hypersensitive, agitated, and began to turn blue. It was believed at the time that a hematoma was blocking his airway. A code blue was put out and, after he lost consciousness, he was re-intubated. From the Post Anesthesia Care Unit, he was rushed into a second surgery which revealed that he had a large hematoma where the surgeon had previously operated. After the second surgery, Moore was found to have suffered a stroke which caused paralysis and severe brain damage. Interestingly, fault could not be readily determined. While the surgeon that performed the first surgery had stated in her deposition that the suture used during Moore's surgery was possibly defective, a nurse testified that the surgeon remarked that she may have tied the suture too tightly. Unfortunately, the suture used was discarded immediately after the second surgery was performed.

The fact that the suture was disposed of is one of the circumstances that separates Moore from the very similar case of Brink v. Ethicon, Inc., 2003 WL 23277272 (Del.Super. 2003). In another faulty suture case, the Brink court granted Ethicon's motion for summary judgment. The court held that the doctrine of res ipsa loquitur was inappropriate because there was no evidence that the "suture material was defective when it was under the control of the defendants." Further distinguishing Brink from Moore was superior lawyering and naming every possible defendant. In Brink, Ethicon, Inc. was the only defendant named in the litigation. Ethicon asserted that the suture failure and resulting injury could have been caused by a doctor not tying the suture correctly, and summary judgment was granted.

Moore's attorneys, Gilbert F. Shelsby and Robert J. Leoni, of Shelsby & Leoni in Stanton, Delaware, named every defendant that could possibly be liable for their client's injury. Since Ethicon's motion for summary judgment had prevailed because the suture was available for expert testing and not all possible defendants were named, Shelsby and Leoni had the foresight to sue each party that could have handled, prepared, used, moved, and/or manufactured the suture. This was pivotal to Moore's case.

Although Moore's action initially named two suture manufacturers it became clear that only sutures manufactured by Ethicon could have been used in Moore's surgery, as the sutures manufactured by U.S. Surgical Corp. were not yet in the hospital's circulation. Both Moore and U.S. Surgical moved for partial summary judgment, seeking a declaration that the U.S. Surgical suture was not used in the first surgery and that the suture used was in fact manufactured by Ethicon. Ethicon opposed Moore's motion but not U.S. Surgical's, even though the success of either motion would mandate that it was Ethicon's suture that was used. In so doing, Ethicon argued that the doctrine of res ipsa loquitur was not applicable to the case because Moore was unable to point to a single defendant and assign that defendant with a "greater probability of negligence" than other defendants. In response to this, Moore's attorneys argued that he had made a prima facie case for negligence to withstand summary judgment and that res ipsa loquitur is applicable.

While there were three issues to be decided, we will only discuss the last one: whether res ipsa loquitur is applicable to this case. "Traditionally, in order to state a successful claim to avoid summary judgment, the plaintiff must negate almost all other potential causes of negligence besides that of the single

defendant.” That being said, Ethicon argued that Moore could not satisfy Rule 304(b) which Delaware trial judges are to employ when deciding whether to give a *res ipsa loquitur* instruction to juries. Of the four elements of the test, Ethicon argued that Moore could not satisfy the first and third, which are as follows: (1) The accident must be such as, in the ordinary course of events, does not happen if those who have management and control use proper care; and (3) The thing or instrumentality which caused the injury must have been under the management or control (not necessarily exclusive) of the defendant or his servants at the time the negligence likely occurred.

Moore argued that his case will eventually be broken down by the jury to the point where they will have to make an “either/or” decision on liability: Moore contends the jury, as in any other basic medical malpractice case, will have to determine whether the doctors, nurses, or hospital were negligent. If not, Moore argues the jury would then, by process of elimination, have no other party left to infer negligence upon except Ethicon for negligent manufacturing of the suture (assuming the Court finds *res ipsa loquitur* applicable here).

With the help of an expert, the Court accepted the latter position and Moore was allowed to proceed on an “either/or” basis. It was essential that all possible defendants be brought into the case. If all possible defendants are not named, then a *res ipsa loquitur* instruction is inherently unjustified. In fact, Moore argued that it was required that all the parties be brought in order for him to successfully argue *res ipsa loquitur* for the control element. If the jury does not find the doctors, nurses, or hospital negligent in its treatment of the patient or handling of the suture, Moore would be entitled to a *res ipsa loquitur* instruction regarding the manufacturer. The doctrine of “Conditional *Res Ipsa Loquitur*” is born in Delaware.

Delaware trial judges still have to employ the four element test for *res ipsa loquitur* cases, even if an “either/or” decision is put to the jury. It is not simply a catchall technique and the chance for abuse is decreased. Manufacturers do have the opportunity to prove that they were not at fault. Perhaps more importantly, it is possible that the jury could find no negligence on either the medical staff or the manufacturer, so it does not seem to be overly prejudicial to the manufacturer defendant as it would initially seem. As Judge Herlihy stated in Moore, the *res ipsa* doctrine “is not a magic bullet which provides automatic victory for a plaintiff and his cause. Even in cases that apply *res ipsa loquitur*, the fundamental rule of negligence still applies: a defendant can never be presumed negligent simply because of the result of an injury to the plaintiff.”

To further explain the process, Judge Herlihy aptly quoted Allendorf v. Kaiserman Enterprises, 630 A.2d 402 (N.J. Super 1993):

[i]f the evidence presents a factual issue as to how an accident occurred, and the *res ipsa loquitur* doctrine would be applicable under only one version of the accident, the court should give a ‘conditional’ *res ipsa loquitur* instruction, under which the jury is directed first to decide how the accident happened and to consider *res ipsa loquitur* only if it finds that the accident occurred in a manner which fits the doctrine.

Even with multiple defendants and multiple scenarios of how an injury came to be, the injury speaks for itself and the plaintiff should, from a public policy standpoint, be able to receive an appropriate measure of damages. The value of conditional *res ipsa loquitur* is that it keeps all possibly liable parties involved so the facts can flesh themselves out and the truth can be found. When asked about the ‘conditional *res ipsa loquitur*’ instruction and its implications, Mr. Leoni made the following statement:

Medical negligence cases can be extremely difficult when they involve alleged medical device failure. The doctor will often assert that the device failed, and the device manufacturer will assert that it did not fail. In the event that the alleged defective device is not available for some reason, then the doctor can point to the device as the cause, and the manufacturer can claim that there is no evidence of device failure since the device cannot be tested, etc. This leaves the Plaintiff in a very difficult situation in which their case can easily be dismissed, even though it is clear that ‘something’ had to have gone wrong. This decision by the Court gives Plaintiffs a chance to present their case to the jury when the proper evidence can be adduced. However, Plaintiffs must work hard in discovery to develop all necessary elements of the various claims.

## The Right to Health: A Response to the Typical Criticism

By Matthew Bilker



Late in 2008, on President Obama's crusade to the Whitehouse, one of his chief and most polarizing platform points was the promise of drastic healthcare reform. After winning the election, his first six months in office have been responsibly devoted to rebuilding the American economy. Recent events, however, have shown that President Obama does not intend to wait for the end of his term, or even the end of his first year, before he begins pushing for a healthcare overhaul.

As President Obama looks to make good on his campaign promise of complete healthcare for all Americans, the opposition cannot move fast enough to provide ample reasons why such a system will not work in the United States. Notably, Michael D. Tanner of the *New York Post*, in his article entitled, "Perils of Obamacare: The Three Big Lies," argued that President Obama's current proposal will force millions of Americans to change their current health insurance plans, force their taxes and premiums up, and will provide the same type of poor quality healthcare that Medicaid and Medicare provide. Further, it is impossible to escape news programs that say a plan that exceeds the cost of one trillion dollars is required to provide health insurance for all of the uninsured in America. As usual, is it impossible for party politics to stay out of the mix, with Senator Jim DeMint (R-SC) leading the way, openly hoping for this healthcare reform to be Obama's "Waterloo." The phrase, "socialized healthcare," is constantly mentioned, undoubtedly to forge the stigma of Communism into state-assisted healthcare. Yet, critics seem to stay away from the real core of the issue: Does being not only an American, but a human, give you the right to health?

46 million. That is the number of uninsured Americans in the country today. This group is a combination of citizens in the low end of the socio-economic strata, independent contractors, legal and illegal aliens, and various other types of Americans, including children. What makes these people different from millions of others around the world? It is the country that they live in. The United States, with all its advances and privileges, is the only major developed country not to implement some form of universal healthcare. How did the citizens of these other developed countries earn the right to health that so many in America are in need of but cannot attain? If the citizens of the educated world have decided they have a right to health, shouldn't the United States follow the trend? How is it possible that these other nations can find programs that work for them but the United States is still squabbling over how to implement such a design?

This article is not intended to provide suggestions on how to pay for a new healthcare system or what variation of healthcare reform works best. It is simply designed to show the urgency that our country has for such reform. The fundamental point is simple: Those in need of healthcare have a right to have it.

However, with such urgency comes caution. President Clinton's epic healthcare reform failure not only doomed his party in the subsequent election, but prevented real reform from being discussed for nearly fifteen years. In wanting this reform to be considered this summer, President Obama is asking, point blank, whether there is a right to health insurance or not. There are many who are willing to answer no to avoid repercussions in other areas (the most notable of which is higher taxes). The risk in pushing this proposal along so fast is too large. There are too many weaknesses in his current plan that critics are seizing. Will the cost controls work? Are there feasible ways to enforce the health insurance mandate? Additionally, public support for the reform is plummeting in part because few lay Americans can understand what the proposal does and how it will work. It looks like since they do not understand it, they are not supporting it. Setting this late summer deadline is a mistake. A setback here could not only doom his healthcare plans for the rest of his term, but for the next fifteen years. The program is much too important and too big to rush. It will not pass without bipartisan cooperation, which at this point, will take time and effort. President Obama says he gets letters every day from those who are begging for healthcare, but in order to properly serve them, he would benefit from taking time to make sure that his plan is the very best that he can put before the public and stand by.

## New Advanced Care Directive Option for Delaware Citizens

By Preet Brassi



A group of local doctors, lawyers (including Widener's own Professor Thaddeus Pope), and nurses are working on implementing a novel type of advanced care directive in Delaware called Medical Orders for Life-Sustaining Treatment Program (MOLST), also known as Physician Orders for Life-Sustaining Treatment Program (POLST), in the state Delaware. This program was developed in the 1990s in Oregon and has been employed in the majority of the states, including: New York, California and Washington. MOLST is not designed to replace Delaware's current advanced directive regulation, Pre-Hospital Advanced Care Directive Regulation (PACD). Instead, it provides people with a choice to select the program that better fits their circumstances and needs.

PACD became effective in 2003 and allows terminally ill patients, upon discussion with their primary physician, the right to elect to either receive full, limited, or no resuscitative efforts by EMS field responders. PACD allows terminally ill patients to choose from three different levels of care and each level defines a specific treatment option. Option A is gives the highest level of care, it is called advanced life support. It instructs medical providers and the EMS field responders to provide restorative care before cardiac arrest then a do not resuscitate order takes effect. Option B is basic life support, which approves only limited palliative care before arrest, then do not resuscitate order. PACD can be revoked at anytime by the patient by providing some sort of communication to the care providers. If a patient decides to participate in PACD the original document is kept with patient's permanent medical records at the facility providing primary care and another copy is kept with the patient.

Similar to PACD, MOLST also summarizes the patient's preference on a bright sheet of paper. The MOLST form is different from the conventional advance directive and PACD, however, because it is a binding medical order that follows the patient from one medical facility to another –and it must be honored by everybody, including emergency personnel and other medical providers without regard to institutional credentialing requirements.

PACD is generally intended for adults, to be completed ahead of time and apply only when the person has lost decision-making capacity. MOLST on the other hand, is for those who are chronically ill or nearing the end of their lives, applies immediately upon memorialization and is not conditioned on losing decision-making capacity.

PACD was established to standardize the legal advanced directive documentation so EMS providers have a readily recognizable format. MOLST has a similar goal. It is designed to improve the quality of care people receive at the end of their lives by translating the patient's preferences regarding their treatment into medical orders. The purpose of this act is to ensure that the clearly expressed preference of a person is honored.

The barrier that we must overcome is proving to the Delaware Division of Public Health that there is a need for POLST in this state and more importantly, they have the power to implement POLST. Since the current advanced care directive regulation is not very different from POLST, it could be argued that the same statutes that provide the Division of Public Health the power to pass the current regulation could also empower the agency to pass POLST. The current regulation is authorized in accordance with 16 Delaware Code, Chapter 97. In order for MOLST to work, we must determine whether it can fit under the same authoritative umbrella. If so, MOLST should prove to be an effective tool in the fight to support patient's wishes.

1. For more information, see the POLST home page, <http://www.polst.org>.

Message to those who wish to submit an article for the Spring Issue for the Colloquium:

There will be a second issue of the Colloquium this spring. If you are interested in submitting an article, please contact Kristopher Kachline at [KAKachline@mail.Widener.edu](mailto:KAKachline@mail.Widener.edu). I would like to give special thanks to Melissa Arnett for her hard work on this issue. Melissa is the vice president of HLS and the architect of the issue. She put in countless hours to make sure the issue was correct. So, thank you Melissa for your hard work.

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