RIVERSIDE LAWYER

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In This Issue:

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RIVERSIDE LAWYER MAGAZINE

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Mission Statement

Established in 1894

The Riverside County Bar Association, established in 1894 to foster social interaction between the bench and bar, is a professional organization that provides continuing education and offers an arena to resolve various problems that face the justice system and attorneys practicing in Riverside County.

RCBA Mission Statement

The mission of the Riverside County Bar Association is:

To serve our members, our communities, and our legal system.

Membership Benefits

Involvement in a variety of legal entities: Lawyer Referral Service (LRS), Public Service Law Corporation (PSLC), Fee Arbitration, Client Relations, Dispute Resolution Service (DRS), Barristers, Leo A. Deegan Inn of Court, Inland Empire Chapter of the Federal Bar Association, Mock Trial, State Bar Conference of Delegates, and Bridging the Gap.

Membership meetings monthly (except July and August) with keynote speakers, and participation in the many committees and sections.

Eleven issues of Riverside Lawyer published each year to update you on State Bar matters, ABA issues, local court rules, open forum for communication and timely business matters.

Social gatherings throughout the year: Installation of RCBA and Barristers Officers dinner, Annual Joint Barristers and Riverside Legal Secretaries dinner, Law Day activities, Good Citizenship Award ceremony for Riverside County high schools, and other special activities.

Continuing Legal Education brown bag lunches and section workshops. RCBA is a certified provider for MCLE programs.

MBNA Platinum Plus MasterCard, and optional insurance programs.

Discounted personal disability income and business overhead protection for the attorney and long-term care coverage for the attorney and his or her family.

The Riverside Lawyer *is published 11 times per year by the Riverside County Bar Association (RCBA) and is distributed to RCBA members, Riverside County judges and administrative officers of the court, community leaders and others interested in the advancement of law and justice. Advertising and announcements are due by the 6th day of the month preceding publications (e.g., October 6 for the November issue). Articles are due no later than 45 days preceding publication. All articles are subject to editing. RCBA members receive a subscription automatically. Annual subscriptions are $25.00 and single copies are $3.50.*

Submission of articles and photographs to Riverside Lawyer will be deemed to be authorization and license by the author to publish the material in the Riverside Lawyer.

The material printed in the Riverside Lawyer *does not necessarily reflect the opinions of the RCBA, the editorial staff, the Publication Committee, or other columnists. Legal issues are not discussed for the purpose of answering specific questions. Independent research of all issues is strongly encouraged.*

Calendar

January

16 **MCLE Marathon**
9:30 am – 2:30 pm
RCBA Building – Gabbert Gallery
RSVP by 1-14-15 to
rcba@riversidecountybar.com
See RCBA website for details:
Riversidecountybar.com

21 **Estate Planning, Probate & Elder Law Section**
Noon – 1:15 p.m. – RCBA Gabbert Gallery
Speakers: Judge Thomas Cahraman &
Attorney Tom Johnson
Topic: "What's New in Probate for 2015"
RSVP by 1-19 to 951.682.1105
Lunch provided, courtesy of Albertson & Davidson, LLP, to those that respond by the deadline

Mock Trial Scoring Attorney Orientation
12:00 – 1:20 p.m.
RCOE – 3958 12th Street, Riverside
Speaker: Judge Jack Lucky
Topic: "Mock Trial Scoring Attorney Orientation: The Fourth Amendment, Apparent Authority, and Scope of Consent"

23 **General Membership Meeting**
Noon – 1:30 p.m.
RCBA Gabbert Gallery
Speaker: Greg Dorst, JD, CAS
Topic: "New Beginnings: Recovery from Addiction"
MCLE: 1.0 hour Competence Issues
(formerly Substance Abuse/Mental Health Issues)

27 **Business Law Section**
Noon to 1:15 p.m.
RCBA Gabbert Gallery
Speaker: Stefanie Field
Topic: "When Business Relations Go Bad: Owners Not Getting Along"

28 **Appellate Law Section**
Noon – 1:15 p.m.
RCBA Gabbert Gallery
A meeting to plan events for the upcoming year.

30 **Bridging the Gap**
A Free Program for New Admittees Only
8:00 a.m. to 5:00 p.m.
RCBA Gabbert Gallery
RSVP – 951-682-1015 or
Email – riversidecountybar.com

February

5 **FBA – IE Chapter**
Judge's Night
Featuring the Honorable George H. King
Keynote Speaker: Laurie Levenson
The Mission Inn – Music Room
Social Hour – 5:00 p.m. /Dinner – 6:00 p.m.
Information – sherrigomez4@gmail.com

President's Message

by Chad W. Firetag

Trouble at the State Bar

If you are like me, I was very surprised a while ago when I opened the *Daily Journal* and saw that former State Senator and State Bar Executive Director Joe Dunn was promptly removed from the State Bar. Then, and almost immediately thereafter, Dunn filed a blistering lawsuit against the Bar and the new Bar President, Craig Holden.

As best as I can gather from the various news reports on the case, Dunn's complaint alleges the following: when Dunn took office in 2011, he was responsible for reducing the backlog of open complaints with the bar. He claims that under State Bar Chief Trial Counsel Jayne Kim's direction, internal reports were altered to remove cases from the statutory backlog. After Dunn made these allegations, Kim then filed a complaint against Dunn to try and preserve her position. After receiving her complaint, Dunn alleges that the State Bar began an internal investigation of Dunn and others by hiring a law firm at a possible cost of more than $300,000 even though a retired state Supreme Court justice offered to do the same evaluation for free. Dunn then alleges that the current state bar president, Craig Holden, and the board of trustees fired Dunn to "assume control over the State Bar's executive functions." Dunn's lawyer, Mark Geragos, later issued a statement further alleging that the case is about the move of the Bar from San Francisco to Sacramento, a move that would generate $50 million profit to the Bar but was nixed by the current State Bar president.

Yikes.

Again, what I've briefly recited is what I've learned from reading the Daily Journal and other news sources. I have no insider knowledge of these events or have an opinion as to the merits of the case. My guess is that by the time my article goes to print, new allegations will have surfaced.

But it occurs to me that this litigation will unfortunately be protracted and costly to the Bar and to its members. And after it is said and done, no matter which party prevails in the litigation the Bar will have a black-eye for some time to come.

And to what end? What will the litigation accomplish?

As lawyers we involve ourselves in litigation every day. And while I agree wholeheartedly that society needs the courts to settle our differences when the parties cannot, in my opinion this isn't the best way that attorneys should act.

It may sound ironic that a lawyer is discouraging litigation, but that is precisely what I think we should strive for. A good resolution leaves all parties happy, or if not happy, much happier than being entrenched in the throes of litigation. Even if you are not particularly religious, I think that most of us can agree with a saying from the Book of Matthew where Jesus said, "Settle matters quickly with your adversary who is taking you to court. Do it while you are still together on the way . . ."

One of the most important things that we as lawyers can do is work in our client's lives to make them better, or if not better, certainly to not leave them in a worse state than we first met them. Except for those rare clients who seem to relish in conflict, I think most of us will agree that lengthy litigation will almost always have a deleterious effect on our clients.

Finding a resolution to a lawsuit, short of litigation, is extremely beneficial to all parties involved. Indeed, the RCBA has a long and proud history of promoting and effectively using alternative dispute resolutions. From the RCBA Dispute Resolution Service, Inc. (DRS) to our Court of Appeal's voluntary settlement program, I think that we can be proud of the work that we have done.

But what is happening in our State Bar is very disappointing to me. I would call on our Bar leaders to put aside these differences and come to a resolution before this litigation gets out of hand. The State Bar has in the past done a good job in showing that lawyers can and should regulate lawyers without interference from outside groups. However, if our own leaders are fighting amongst each other, how can we expect the public to believe that we should govern ourselves?

It is unknown what effect the Dunn litigation will have on the Bar. Perhaps all parties can come to a quick resolution. My guess is that given all that has been alleged, it probably will not resolve soon. In the end, it may turn out to be an embarrassment for those involved but I surely hope not. We as lawyers can make great strides in our communities, but in order to encourage others to act amicably, the leaders of our Bar have to act accordingly. My hope is that the parties will resolve this case quickly so that the Bar can get back to business – time will only tell.

Chad Firetag is an Assistant Public Defender for the Law Offices of the Public Defender, Riverside County.

Barristers Board – Member's Message

by Eli Underwood

When Scott graciously asked me to write about my experience as a new attorney, I was certain of the one thing I wanted to communicate to all new lawyers that might come across this article: Learn how to be a lawyer by coaching mock trial.

As many new attorneys can attest, law school often teaches very little about the every-day realities of practicing law. Beyond just reading cases, like *Pennoyer v. Neff* and *International Shoe*, there is a whole world to learn about in the practice of law. Namely getting up and speaking in front of people, and attempting to convince them to see things your way. Counter-intuitively, I felt even less prepared to practice law after law school because I had been told by my law school and the State Bar that I knew what I was doing when I felt deep down that I didn't.

After struggling through the first couple months of getting my sea-legs as a lawyer, I was invited to act as an attorney-scorer for a county mock trial competition. As a recent law graduate and new attorney, my expectations were that high school kids could only fumble around while pretending to be the lawyer that I had just qualified to be. Instead, I was incredibly impressed by these teenagers who not only seemed more lawyerly, but also seemed to know the law better too! Their ease and comfort in the courtroom and with legal procedure revealed to me how much I still needed to learn.

As a result, I volunteered to coach a high school mock trial team, and have been coaching for the last three years. This has been more than just a learning experience, it has been incredibly rewarding to teach and mentor young minds who are so eager to learn about the law, as well as a great opportunity to give back to the community.

Through this experience, I also found the truth in the statement that "the best way to learn something is to teach it." As I have progressed in my career, I am constantly reminded of the lessons I've learned by teaching mock trial: respect for the listener, getting to the point quickly, the importance of taking opposing arguments head-on, professionalism and comity in the courtroom, and an even greater respect for a judge's job.

To all new (and maybe some more seasoned) attorneys, there is always more to learn when it comes to the law. And the best way to learn it is by teaching mock trial.

All are invited to attend a debate and discussion of ethics and access to justice issues between District Attorney Michael Hestrin and Public Defender Steve Harmon on Friday, January 9, 2015, from 12:00 p.m. to 1:30 p.m. Presiding Judge Harold Hopp will be moderating this extraordinary event. Please bring your own lunch. We hope to see you there!

Eli Underwood is a Member-at-Large of the Barristers Board and practices eminent domain law with the Hubbard Law Firm.

The 2014 Ebola Outbreak

by G. Richard Olds, M.D.

The 2014 Ebola outbreak – by far the most devastating since the disease was first identified in the mid-1970s – is not only raising questions about how we contain the epidemic, but is also fueling a vigorous debate between infectious disease experts and public policymakers. Disagreement surrounds appropriate safeguards for physicians and other health care professionals when treating desperately ill patients, as well as the appropriate safeguards for our population when health professionals return from West Africa.

Our health care system was caught largely off guard last summer when the Ebola epidemic gained steam in several nations in West Africa and when infected individuals, including humanitarian health care providers, began arriving back in the U.S.

The first patient diagnosed in the U.S. was initially misdiagnosed and sent home from a Texas emergency room. He was later hospitalized but died. Two health care workers who provided care for him subsequently became infected, drawing attention to probable shortcomings in the training and preparation of health care workers for handling such illnesses.

What we have also seen are several cases of overreactions to a disease that is devastating when contracted, but in fact, is not easily spread. Increasingly, politicians and public policymakers are not basing decisions on good public health and medical knowledge.

Unlike influenza or tuberculosis, Ebola is not transmitted by airborne aerosols from an infected person sneezing or coughing. Direct contact with bodily fluids, such as saliva, feces or vomit, or syringes contaminated by the virus, are the well-established means of transmission for Ebola. In addition, asymptomatic people are not infectious and are very unlikely to transmit the virus until they are very sick, generally several days after symptoms appear.

After it became known that one of the nurses treating the first U.S. patient had taken a flight from Cleveland to Dallas in October 2014, the airline put the flight crew on paid leave and two schools closed temporarily – both unnecessary actions that served only to raise the level of anxiety among the U.S. public.

The very same month, a teacher from Maine was put on a 21-day leave after having attended a conference in Dallas, the city in which the first patient was treated and died. Parents in a Mississippi city pulled their children from school when they learned the school's principal had attended a family funeral in an African nation far from the hot zone countries of Liberia, Sierra Leone, and Guinea.

In New York and New Jersey, quarantine protocols were put into place for asymptomatic health care workers who arrived from West Africa at their international airports after having cared for Ebola patients, even though the Centers for Disease Control (CDC) had not issued that recommendation. One such traveler, a nurse, protested her quarantine and was subsequently permitted to self-quarantine at her home in Maine. She later defied the order, challenged it in court, and was permitted to abide by the less-restrictive CDC recommendations.

Here in California, in November Cal/OSHA, the state agency concerned with the health and safety of all workers, issued guidance for hospitals in the state to protect their employees from Ebola infection.

Worker safety is of course very important, but a mandate that hospitals institute airborne transmission controls contradicts evidence that Ebola is not transmitted in that way. Mandatory airborne-level personal protective equipment, to include the use of air-purifying respirators, provides no additional benefit to health care workers and may, in fact, hinder communication with the patient and other members of the health care team. Again, this is in contrast with CDC recommendations and has the effect of increasing fear among health care workers as well as members of the public.

The 2014 Ebola outbreak has clearly tested the balance between public health and public fear. Any disease with such a high case fatality rate is both frightening to the general public and poses a very serious public health challenge. But decisions should be based on scientific knowledge and hard evidence.

We should also be aware that the real battle against Ebola must be fought now in West Africa, a location with grossly inadequate facilities and painfully short of trained health professionals. U.S. doctors and nurses who are risking their lives in the service to others are true heroes. Let's not make their lives more difficult when they do not pose a public health threat to our population.

This is not the time to panic. This is not a time for hysteria or misinformation. This is a time we need to identify potential cases. If we have the protocols to handle patients with Ebola and we appropriately train health care workers to carry out those practices, we can be confident that this disease will not pose a major public health threat in the U.S. For those U.S. doctors and nurses who have traveled to West Africa to fight on the front lines of this epidemic, I hope we as a nation afford them the same respect we give to our returning veterans.

G. Richard Olds is Vice Chancellor of Health Affairs and the founding dean of the U.C. Riverside School of Medicine, as well as an infectious disease authority.

Passage of Gun Control Legislation Looks to Fill Void in State's Mental Health System

by Dana Vessey

On September 30, 2014, Governor Brown signed Assembly Bill (AB) 1014 into law, making California the first state that allows concerned family members—in addition to law enforcement officers—to petition a court to obtain a gun violence restraining order. Introduced in the wake of the Santa Barbara shootings earlier this year that killed six and injured 13, AB 1014 authorizes the issuance of a restraining order where a judge finds that there is sufficient evidence the subject individual presents an immediate and present danger of causing personal injury to himself, herself, or another by having in his or her custody or control, owning, purchasing, possessing, or receiving a firearm.

The legislation focuses on enabling preventative action. While California law prohibits gun possession or ownership by those who have been involuntary committed or declared mentally incompetent, prior to AB 1014, there was no legal recourse available to family members or law enforcement officers who become aware of potential warning signs of violent behavior that either fall short of satisfying the standard under Welfare and Institutions Code section 5150 or those that are simply unknown to investigating officers.

For instance, following the Santa Barbara shootings, it was learned that just days prior, the shooter's family had seen warning signs of violent behavior and reported it; however, when officers visited the shooter to evaluate his behavior, he acted calm and cooperative. Also, the officers had no information regarding gun ownership or the shooter's history of mental health issues—leaving both law enforcement and the shooter's family without legal recourse to take any sort of preventative action. Moreover, despite the shooter's history of mental health treatment, he was able to pass a background check for weapons ownership since he had not undergone any of the events giving rise to a legal prohibition to ownership.

AB 1014, modeled after existing domestic violence restraining orders, provides an alternative recourse to the emergency psychiatric evaluation and gun confiscation procedure available to law enforcement officials. Currently, to detain an individual under Welfare and Institutions Code section 5150, a peace officer must be aware of facts that would lead a person to believe, or entertain a strong suspicion, that the person detained has a mental illness and is gravely disabled or a danger to self or others. Only upon such a determination can law enforcement confiscate any weapons in the detained person's possession, custody, or control. (Welfare & Institutions Code section 8102.) Thereafter, the law enforcement agency may petition the court to have the weapons destroyed if return of the weapons is likely to endanger either the detained person or others.

Under AB 1014, law enforcement or family members can seek an ex parte gun violence restraining order from a court, during regular court hours, prohibiting the subject of the petition from having custody or control, owning, purchasing, possessing, or receiving, or attempting to purchase or receive, a firearm or ammunition. To obtain the restraining order, it must be shown that there is a substantial likelihood that the subject of the petition poses a significant danger to self or others in the near future by having access to a firearm.

In lieu of this ex parte procedure, a law enforcement officer may petition a court—at any time of day or night—for a "temporary emergency" gun violence restraining order. To obtain this emergency order, a law enforcement officer must show and the court must find that there is reasonable cause to believe that the subject of the petition poses an "immediate and present" danger of causing injury to self or others by having access to firearms.

Both a temporary emergency order and an ex parte order require the subject of the petition to voluntarily surrender all firearms and ammunition owned or possessed by the subject and bars them from attempting to purchase or receive firearms for the duration of the order, up to 21 days. The orders are entered into a computer database maintained by the Department of Justice. Should the subject fail to voluntarily surrender the firearms, the bill authorizes the issuance of a search warrant to seize the weapons or ammunition in possession of a restrained person.

Each order under the new law expires no later than 21 days after the date of the order and also requires the court to hold a hearing within that time to determine if a one-year gun violence restraining order should be issued. A one year restraining order can be issued if the court finds, upon clear and convincing evidence, that the subject of the petition poses a significant danger to self or others by having possession or the ability to obtain firearms. AB 1014 further authorizes the renewal of a one-year order for

additional one-year periods and permits the restrained person to request a hearing to terminate the order during the effective period.

Critics have attacked AB 1014 for its infringement on the Second Amendment rights of potential subjects of gun violence petitions. Concerns have also been raised regarding falsified petitions or those filed to harass. In response to those concerns, the bill makes it a misdemeanor to file a petition knowing the information is false or with the intent to harass the subject of the petition.

Proponents of AB 1014 hope the new legal mechanisms will give family members and law enforcement tools to prevent future tragedies before it is too late. The new law takes effect on January 1, 2016.

Dana M. Vessey is an associate in the Municipal Law and Litigation practice groups of the Ontario, CA office of Best Best & Krieger LLP. Dana serves as city prosecutor to several cities, oversees gun confiscation matters and advocates on behalf of public agencies in both state and federal court.

Is Ebola a Legitimate Threat to Americans?

by Richard Pitts, D.O., Ph.D.

Americans, for the most part, lead an idyllic life when it comes to deadly infectious diseases. That idyllic illusion was shattered when two of the nurses caring for Thomas Duncan, the Ebola patient from West Africa who was treated in Dallas, Texas, came down with Ebola themselves. Although the investigation continues, the likely cause of the Ebola infection in the two nurses has to do with a breakdown in personal protective equipment protocols while he was gravely ill.

Since that time we have learned a lot from the unfortunate case of Mr. Duncan. Contrary to common thought, it seems that the risk of catching Ebola for the general public in the Western World is not zero, but very close to zero.

What evidence is there to support this view? It has been widely reported that before Mr. Duncan was admitted to the Dallas Hospital, he was living with several people and had intimate relations with his fiancée. It is now well beyond the incubation period for Ebola, and no one who resided with Mr. Duncan has Ebola.

However, for health care workers, the situation is very different depending on how ill an Ebola patient is. Health care workers are exposed to potential infection from an Ebola patient while drawing blood, performing procedures that cause aerosols and, as the disease progresses, being exposed to up to two to three gallons of vomit and diarrhea produced daily by a gravely ill Ebola patient.

In poor countries, the vast quantity of infectious liquids is simply not able to be dealt with and leads to spread of the disease. As well, the cultural norm of bathing a loved one and then pouring the collected contaminated bath water over the heads of all family members is an easy way to catch Ebola. The bath water could have several billion viral particles-each one capable of infecting someone.

It is clear from the nearly 50 years of combined experience of the four United States hospitals that have "Biologic Safety Level-4 Severe Communicable Disease Units" that the risk to health care workers can be successfully managed with proper protocols. None of these hospitals have reported a health care worker infection from patients for whom they provided care.

In my opinion, the real problem with the Ebola cases in the United States was not the disease itself but the uncertainty and less-than-optimum communication of what was happening. I have treated over 125,000 people in my career as a physician. Whether it is cancer or an infectious disease, I can say with certainty that what patients and families fear the most when it comes to a deadly disease is uncertainty. And uncertainty was what was feeding the fear of people in the United States when Mr. Duncan fell ill.

The November 4th edition of the *Orange County Register's* University Section featured an article by Chapman University's Professor Lisa Sparks, a professor of communication studies and a health care communications expert. In that article, Professor Sparks laid out a critical discussion about how to handle crisis communications – helping to deal with the issue of uncertainty.

Professor Sparks wrote that there was inconsistent information about how Ebola is spread and confusion about what to do with an Ebola patient. The news media was rife with "mixed messages" with what level of personal protective equipment was required to safely handle an Ebola patient - a convenient topic for the news media and others to take advantage of and create a great deal of anxiety for the general public and health care workers in particular. To me, of all the points that Professor Sparks made in her article, the most important one is to not speculate. "If you don't know something, say so." Other points that Professor Sparks made include, "Use everyday words, avoid the dreaded 'no comment,' don't say anything you don't want to see in print the next day, and don't lie-you won't get away with it."

Communication issues aside, catching Ebola in the United States is highly unlikely. There is a more present danger with other deadly communicable diseases. The chance of catching one of these other diseases if you have not been vaccinated is highly likely. It only takes one cough in the same room. Are you up to date on your vaccinations?

Dr. Richard Pitts. D.O. Ph.D., is the Medical Director at Arrowhead Regional Medical Center in Colton, California.

Intersection of End of Life Care and Death with Dignity Laws

by Sarah Mohammadi

Death with dignity laws allow mentally competent, terminally-ill adult state residents to voluntarily request and receive prescription medication to assist in expediting their deaths. Only three states have passed death with dignity legislation[1], and advocates have been fighting an uphill battle to change the laws' negative perception that had been created by Dr. Jack Kevorkian in the 1990's. Despite increasing support to give terminally ill patients more control over their end-of-life care and the acknowledgment that autonomy is central to the debate[2], these laws continue to be incredibly controversial.[3] Much of this controversy surrounds the idea that aid in dying violates the Hippocratic oath[4] and that doctors could make mistakes about patients, resulting in the ultimate price.

In an effort to mitigate concerns surrounding death with dignity legislation, the states that have implemented this legislation have designed a series a safeguards.[5] In order to qualify, patients must be 18 years or older, a resident of Oregon, Washington or Vermont (no minimum length of residency requirement), mentally competent to make and communicate health care decisions, and diagnosed with a terminal illness that will lead to death within six months. Two physicians must determine that the aforementioned criteria are met and if either physician determines that the patient's judgment is impaired (including if that patient is suicidal), the patient must be referred for a psychological examination. The physician also must inform the patient of alternatives, including palliative care, hospice, and pain management options and must request that the patient notify their next-of-kin of the prescription request. Lastly, there are a series of short waiting periods between requests that the patients must make to the physician, both oral and written before being able to obtain a prescription.

Despite these safeguards, the resistance to these laws remains palpable and is often grounded in notions of morality. However, morality is necessarily subjective and there are no procedural safeguards that can mitigate those concerns. Specifically, persons of particular religious persuasions are opposed to an individual taking their own life, while others think the choice demeans the value of human life or could prevent the occurrence of medical miracles. However, there is potential for proponents of death with dignity legislation to take meaningful strides towards providing this option to patients in light of a separate and serious issue within the United States healthcare system.

There is no question that the United States overspends on health care. One particular area of concern is the monumental expense of end-of-life care. According to the Center for Disease Control and Prevention (CDC) the total federal spending on health care was nearly 18% of the nation's output in 2011[6], approximately double what most industrialized nations spend on health care. Medicare accounted for close to $554 billion, which is approximately 21% of the total spent on U.S. health care that year and of that, $170 billion, or approximately 28% of Medicare spending is allocated to services in the last six months of life.[7] This figure is not inclusive of any end-of-life

1 Or. Rev. Stat. §§ 127.800-127.995; Wash. Rev. Code §§ 70.245.010-70.245.904; Patient Choice and Control at End of Life Act (18 V.S.A. Chapter 113, Act 39)

2 Barry Rosenfeld, *Assisted Suicide and The Right to Die: The Interface of Social Science*, Public Policy, and Medical Ethics 9, 44 (2004).

3 An attempt to include a provision in the Affordable Care Act offering patients end-of-life consultations with their physicians was removed from the bill after Sarah Palin called it a "death panel".

4 Paul Carrick, *Medical Ethics in The Ancient World* (Georgetown University Press, 2001).

5 Death With Dignity National Center, Death with Dignity: the Laws & How to Access Them < http://www.deathwithdignity.org/access-acts > (2014)

6 Centers for Disease Control and Prevention < http://www.cdc.gov/nchs/fastats/health-expenditures.htm >

7 *Kaiser Health News*, http://kaiserhealthnews.org/morning-breakout/end-of-life-care-17/ > (citing The Medicare NewsGroup, http://www.medicarenewsgroup.com/context/understanding-medicare-blog/understanding-medicare-blog/2013/06/03/end-of-life-care-constitutes-third-rail-of-u.s.-health-care-policy-debate >.)

health care costs for individuals outside of the Medicare system.

This issue, no matter how sensitive, warrants serious attention and federal policymakers have continually been directing their efforts at reducing end-of-life health care costs. With the implementation of the Affordable Care Act, concerns about the rationing of health care, with a particular focus on end of life medical care, have found their way to the forefront of the health care landscape. Whether or not the fear of rationing is a legitimate one, that fear along with the undeniable costs associated with ignoring the problem could result in end-of-life care predicaments facilitating the passage of more death with dignity laws. If the United States is severely overspending on healthcare, are we more willing to curtail those expenses by allowing individuals to make end-of-life health care decisions for themselves? By affording terminally ill individuals autonomy over their end-of-life health care decisions, we could take a meaningful step in cutting costs, promoting patient autonomy, and avoiding the dreaded rationing of care. If death with dignity laws were ultimately passed because of exponential end-of-life health care costs, then it appears that we will have taken this issue outside the scope of its original moral underpinnings and could potentially lose the merits of the controversy in the numbers. However, so long as states continue to provide substantial safeguards in this legislation to protect both patients and doctors, this may be an instance where the means are not nearly as significant as the end.

Sarah Mohammadi is an attorney at Best Best & Krieger, LLP in the labor and employment practice group. At UC Hastings Sarah served as a research assistant and a teaching assistant for Health Law I and II and Bioethics.

When Acronyms Collide: HIPAA, BYOD, ePHI and OCR

by D. Brian Reider

Two years ago, health care providers had a wake-up call when the federal Department of Health and Human Services Office for Civil Rights ("OCR") announced the assessment of a $100,000 fine against Phoenix Cardiac Surgery, a small provider of cardiothoracic surgery physician services, based upon an investigation of alleged impermissible disclosures of electronic protected health information (ePHI). Among other things, it was asserted by OCR that there were over 1,000 separate entries of ePHI on a publicly accessible, Internet-based calendar, and daily e-mails containing ePHI which were not properly protected. The OCR brought its claims as violations of the Privacy Rule which is part of the regulations implementing the Health Insurance Portability and Accountability Act ("HIPAA").

In early 2013, additional rules were adopted under HIPAA and the related Health Information Technology for Economic and Clinical Health Act (HITECH), greatly expanding the requirements for protection of ePHI, as well as the requirements for notifications when data breaches occurred. Meanwhile, the OCR penalties for data breach violations have kept coming, including a $1.7 million fine in July of 2013 against Well Point for alleged security weaknesses in an online application database which left the ePHI of 612,402 individuals accessible to unauthorized individuals over the Internet.

In the midst of these events has come the incredible rise in use of devices including smart phones and similar devices. Back in the Dark Ages (before the introduction of the iPhone in 2007 and the Android a year later), the greatest risk of ePHI disclosure violations on a mass scale was through computer networks which at least could be monitored and somewhat secured and controlled.

But as the new smart phones, with texting, e-mail and camera capabilities proliferated (nearly 60% of the people in the United States own such devices), so did another phenomena: the rise in the use of these privately owned devices at work. Often referred to as the "BYOD" (Bring Your Own Device) phenomenon, this has in turn created a collision course between the highly restrictive HIPAA protections as enforced by OCR, and the desire of employees to bring their devices to work and use them as important tools.

The problems posed by BYOD are sometimes obvious, but not always. "Protected Health Information" very broadly consists of information about a person's physical or mental health, their treatment, and their payment for treatment. It is protected if it is transmitted electronically and it contains one or more of 18 "markers," including obvious ones such as the patient's name and address, Social Security or medical record numbers or telephone numbers, but also less apparent information including internet protocol (IP) addresses, photographs and any other characteristic which could uniquely identify the individual. Once PHI becomes "ePHI," it must be protected from disclosure to anyone who is not authorized to receive or view the information.

Unfortunately, smart phones and tablets in particular lend themselves very well to violations of these rules. Imagine Patient X being treated in a local hospital. She presents with an odd rash. Wanting to be able to share its appearance with a consulting dermatologist, Dr. A pulls out his smart phone and photographs the rash, and texts it to Dr. B with a quick note: "What do you think?" While waiting for a response, Dr. A makes a note in his smart phone to forward the photo later to Patient X's chart, with a brief note of her name as "Ms. A.L." Later that day, Nurse C. tries to decipher some of Dr. A's notes, and she e-mails him from her iPad to ask for clarification, providing some of Patient X's history and insurance information. Patient X proves to be a bit of a complainer, and after his shift, Nurse D posts on his Facebook account "So glad to be home for working in the [hospital name] ER – absolutely crazy woman with a really gross rash made the shift really bad!"

Each of these events is likely a HIPAA violation. To make it worse, if Dr. A's smart phone is then hacked or stolen, or Nurse C's iPad suffers the same fate, the consequences could be even more catastrophic, including making Patient X a victim of identity theft.

Short of an outright ban on personal devices, what is a health care provider to do? At a bare minimum, three critical steps should always be taken:

- Policies have to be created and adopted which clearly spell out the use of personal devices. Strong passwords must be required, and everyone bringing a device to work must be required to immediately report any unauthorized intrusions or losses of the devices.
- Regular, documented training, must be given to every employee who is allowed to bring a personal device to work. The HIPPA rules regarding e-PHI must be thoroughly explained, particularly the nuances concerning such acts as photographing any part of the patient's body or otherwise disclosing enough information to allow someone to "connect the dots" and identify the patient.
- Consideration should be given to the purchase and mandated use of applications which would limit the use of the devices, including restricting the types of other applications which can be on the personal device. Where data transmissions are permitted, they should always be encrypted if they relate at all to the workplace.

Unfortunately, there is no one single "magic bullet" that will prevent violations. However, taking affirmative steps such as these may go a long way to head off hefty penalties should OCR come knocking on your door.

D. Brian Reider is a partner at Best Best & Krieger, LLP. He provides legal services to healthcare and other service providers throughout Southern California. He can be contacted at Brian.Reider@bbklaw.com.

The Most Strange and Complex World of Health Care Bankruptcy

by Jerry Seelig

A box is checked on the Voluntary Petition—Form B—of the initial bankruptcy filing documents, which states that the debtor is a "health care business." Health care business, now the *health care debtor* is defined in the Bankruptcy Code as "any public or private entity (without regard to whether that entity is organized for profit or not for profit) that is primarily engaged in offering to the general public facilities and services for: (i) the diagnosis or treatment of injury, deformity, or disease; and (ii) surgical, drug treatment, psychiatric, or obstetric care." This definition spans the spectrum of large and small health care providers, rural and urban hospitals, multiple-specialty practices, nursing homes, sole practice dentists, optometry practices, chiropractors, and physical therapists.[1]

As in all bankruptcies, the interested parties are now in a fight for who owns what, who gets to control those assets during bankruptcy, who creates the plan to establish post-bankruptcy ownership, and how much money the creditors get when the organization emerges from bankruptcy. Yet, be warned: health care debtors are different, *very, very, very* different.

The readers of this article may some day or have in the past represented a party in health care bankruptcy, therefore it is important that we examine why health care bankruptcy is different. What follows is an explanation of why health care bankruptcy is different, what challenges are created for all parties, and some help that may be available to those involved in health care bankruptcy cases.

Difference Number One: *Assets are not an auto-parts assembly line or a restaurant stove. General Motors or Rick's Café do not have the health and safety of patients to worry about nor is their ability to make bumpers or serve hash browns bound by accreditations, licenses and provider numbers, and complex reimbursement methodologies.*

In pleading for the removal of a physician serving as responsible officer, Talitha Gray Kozlowski summarized the differences best when she argued: "*While life and death discussions in bankruptcy cases are usually hyperbole, here it is not. In this unique circumstance, denial of the relief sought will endanger lives, place Debtor's licensure in jeopardy, and render a reorganization improbable*."[2] What that means for you is that stakeholders in your health care case, including some very powerful federal and state regulators, could state in writing or loud voices the following:

- Care has severely declined,
- Staffing has gone to hell,
- The person who got us in this mess still has the checkbook and will soon kill someone because they do not have enough money and/or they are making bad choices with the few dollars.

You may assume that your health care client would not deliberately set out to harm patients. After all a health care provider is a business whose key mission is for patients to receive quality care delivered by competent personnel (physicians, nurses, pharmacists, etc.). Yet the business end of a health care bankruptcy debtor may very well be driven by cost-containment, which may negatively impact patient safety due to caregivers having fewer resources. What if the financially strapped heath care client decides (with or without your input) to cut staffing expenditures as a means of balancing the books? The potential harm to patients has increased significantly and the state and federal regulators and other payers can slow or stop your billing and/or sweep away any cost-savings with demands for new expenditures to support improved patient care.

Difference Number Two: *The operating or now-shuttered bumper manufacturer or coffee shop does not have to safeguard confidential patient information.*

Every one's medical records, be they paper, electronic or as is the case in most providers a combination of both, contains highly confidential patient information. Looking at your own medical record you will immediately grasp

1 11 USC § 101 (27A) The term "health care business"– (A) means any public or private entity (without regard to whether that entity is organized for profit or not for profit) that is primarily engaged in offering to the general public facilities and services for–(i) the diagnosis or treatment of injury, deformity, or disease; and (ii) surgical, drug treatment, psychiatric, or obstetric care; and (B) includes–(i) any-(I) general or specialized hospital; (II) ancillary ambulatory, emergency, or surgical treatment facility; (III) hospice; (IV) home health agency; and (V) other health care institution that is similar to an entity referred to in subclause (I), (II), (III), or (IV); and (ii) any long-term care facility, including any–(I) skilled nursing facility; (II) intermediate care facility; (III) assisted living facility; (IV) home for the aged; (V) domiciliary care facility; and (VI) health care institution that is related to a facility referred to in subclause (I), (II), (III), (IV), or (V), if that institution is primarily engaged in offering room, board, laundry, or personal assistance with activities of daily living and incidentals to activities of daily living.

2 In re: Primecare Nevada Inc. DBA Nye Regional Medical Center, "Motion To Appoint Responsible Officer And Directors Of Debtor," Case 13-20348-Led Doc 328, page 4, lines 21-22

the unique challenge of what I find to be both health care provider's asset and liability. Every medical record contains vast amount of personal and sensitive information on an individual's health, history, and financial matters, which is an integral part of a patient's treatment course.

Most importantly, in or out of bankruptcy, the medical records are owned by the provider (your client), not the patient. The health care debtor owns and the debtor's counsel or advisor inherits the challenge of maintaining, protecting, and making available when appropriate the patient confidential information found in those shelves or megabits of medical records.

Virtually every one knows of HIPAA, the often-misspelled acronym for the federal Health Insurance Portability and Accountability Act of 1996. HIPAA makes confidential client information security and availability enforced by multiple state and federal agencies. The key enforcement agency, Office of Civil Rights for the Secretary of Health and Human Services, can and will make you report when confidential patient information has been breached and they can and will levy large fines for privacy breaches.

Perhaps this first came to your attention in 2007 when a former administrative assistant at Ronald Reagan UCLA Medical Center was indicted by a federal grand jury for selling patient information to the *National Enquirer*. Sixty-eight current and former staff, including nine doctors, had been sneaking peeks at the records of famous patients.

No rich and famous in your client's practice, well how about the bad former boy-girl friend, the cousin who cannot be revealed as a drug user, or an employee's child who is an occasional pot user? Can you count on no one ever taking a chart home from the office for review or to call a patient? Yet doctors and employees do. What about the doctor's or employee's laptop containing hundreds, thousand or a million medical records that can be and has been stolen from a car?

Not going to happen to your client? That may be a bad bet in that 29.3 million patient health records were compromised in HIPAA data breaches since 2009.[3]

The Bankruptcy Abuse and Consumer Protection Act of 2005 require a decision by the court to "Appoint a Patient Care Ombudsman or state that facts make that appointment not necessary."[4] The Bankruptcy Abuse and Consumer Protection Act created the patient care ombudsman and for some cases a consumer privacy ombudsman[5] as a way to protect patient's health care information. Bankruptcy courts often admit to having little understanding of health care rules, regulations, and the risks that health care providers face both in and out of bankruptcy. Therefore, often nationally and in virtually every health care bankruptcy case in the Central District of California, the Unites States Trustee has made the patient care ombudsman appointment. By appointing a patient care ombudsman or in some instances a consumer privacy ombudsman, the United States Trustee and their attorneys with the support of the court recognize the critical need, from a patient safety perspective, to have an independent monitor.

The ombudsman is neither an employee nor consultant of the debtor and does not have a financial stake in current and post-confirmation operations. Accordingly, the ombudsman provides patients and their caregivers an independent voice that can express patient concerns directly to the court and all parties in interest.

Jerry Seelig is President of Seelig + Cussigh HCO LLC, which provides consulting services to health care providers and governmental agencies. He has served as a patient care ombudsman 16 times, a consumer privacy ombudsman in four health care cases, Chapter 11 Trustee for a home health nursing company, and most recently first as patient care ombudsman, then as Responsible Officer, and now is in a final role as CEO at Nye Regional Medical Center, Tonopah NV.

3 Erin McCann, HIPAA data breaches climb 138 percent Posted on Feb 06, *Healthcare IT News*, http://www.healthcareitnews.com/print/75256

4 BAPCPA in 11 USC § 333 (b) states: An ombudsman appointed under subsection (a) shall–(1) monitor the quality of patient care provided to patients of the debtor, to the extent necessary under the circumstances, including interviewing patients and physicians; (2) not later than 60 days after the date of appointment, and not less frequently than at 60-day intervals thereafter, report to the court after notice to the parties in interest, at a hearing or in writing, regarding the quality of patient care provided to patients of the debtor; and (3) if such ombudsman determines that the quality of patient care provided to patients of the debtor is declining significantly or is otherwise being materially compromised, file with the court a motion or a written report, with notice to the parties in interest immediately upon making such determination.

5 BAPCPA in 11 USC § 332. Consumer privacy ombudsman (a) If a hearing is required under section 363(b)(1)(B), the court shall order the United States trustee to appoint, not later than 5 days before the commencement of the hearing, 1 disinterested person (other than the United States trustee) to serve as the consumer privacy ombudsman in the case and shall require that notice of such hearing be timely given to such ombudsman. (b) The consumer privacy ombudsman may appear and be heard at such hearing and shall provide to the court information to assist the court in its consideration of the facts, circumstances, and conditions of the proposed sale or lease of personally identifiable information under section 363(b) (1)(B). Such information may include presentation of– (1) the debtor's privacy policy; (2) the potential losses or gains of privacy to consumers if such sale or such lease is approved by the court; (3) the potential costs or benefits to consumers if such sale or sublease is approved by the court; and (4) the potential alternatives that would mitigate potential privacy losses or potential costs to consumers. (c) A consumer privacy ombudsman shall not disclose any personally identifiable information obtained by the ombudsman under this title.

The MSM Blood Donation Ban

by Christopher Marin

With the recent Ebola scare, epidemiologists have once again experienced a career boost as their profession takes on newfound prominence in the national news cycle. I am sure more than a few of us attorneys are regretting our foray into law instead of public health. However, I am not here to talk about our most recent epidemic, but rather one that is decades old with ramifications still felt to this day: the emergence and spread of the Human Immunodeficiency Virus or HIV, and its related disease, Acquired Immunodeficiency Syndrome (AIDS).

For most of us, our recollection of the emergence of HIV/AIDS in the U.S. dates back to the early 1980's, when the medical community noticed some very rare opportunistic infections commonly associated with weakened immune systems were starting to develop in populations of gay men at an alarming rate. Seeing the "what," but not understanding the "why" or the "how," the medical community urged caution among sexually-active gay men. That message was not well-received but was rather interpreted as another means to oppress this group that had since made great strides in their fight for civil rights and mainstream acceptance over the past decade. Also not helping the public health cause was the fact that the federal government was seen as oblivious or willfully ignorant to the emerging crisis because of the "undesirability" of the patients, highlighted by the fact that President Reagan made no mention of the disease publicly until 1985. The media, however, did latch onto the crisis message and started labelling this mystery disease as Gay Related Immune Deficiency or GRID.

The atmosphere of fear, ignorance, and moral disapproval associated with the emergence of HIV/AIDS made for an ideal atmosphere for scapegoating gay men and homosexuality in general. Not helping matters, in 1983, the FDA issued an indefinite deferral on blood donations from men who have had sex with men (the MSM in the title) at any time since 1977. Women who have sex with MSMs face a blood donation deferral of one year after the sexual contact.

At the time the deferral was adopted, these precautions made sense. Very little was known about HIV or how to detect it (early testing looked for Hepatitis as a correlated proxy disease). Even when knowledge and testing started to emerge, there was still a big window between infection and detection that lasted longer than donated blood would have been usable. However, medical science has made remarkable strides in the treatment and detection of HIV. Blood tests are now sensitive enough to detect HIV (if it is present) within the window of blood's usability. Understanding of the virus has even allowed the development of antiretroviral therapies that prevent the disease from infecting a healthy individual either before or shortly after they are exposed to HIV — referred to as pre-exposure and post-exposure prophylaxis.

Despite the incredible strides in understanding HIV, the FDA policy remained stuck in 1983. That is until December 23, 2014, when the FDA issued a policy change for a deferral for one year after an individual's last MSM contact extend to both men and women. Since this development came after deadline for this article, it still remains to be seen what will happen when this regulation meets with congressional "oversight."

Gay rights' groups' reactions to the shift in policy have been mixed.[1] Some see the step as a positive incremental change towards the eventual lifting of the policy. Others still see a one year celibacy requirement for men as a continuation of the oppression of this sexual orientation minority. This oppression is made all the more glaring considering there is no ban on heterosexuals who have had heterosexual sex within the last year, even though that also carries a high risk of transmission of HIV. We currently have blood tests than can detect HIV infection as early as nine days after exposure and this has led other countries to lift their MSM blood donation deferrals entirely. And last, but not least, it leaves a large untapped population willing to help fill a shortage of needed blood and blood parts.

Even this new deferral does not address some of the dangerous cultural impacts of such a ban. First, it continues to conflate the population of gay men to living with HIV. Second, it creates a stigma around HIV that discourages at-risk individuals from getting tested.

1 http://www.nytimes.com/2014/12/24/health/fda-lifting-ban-on-gay-blood-donors.html?_r=1

And finally, as with any scapegoat, it replaces society's fear of gays and HIV with a false sense of security. As someone who grew up gay in the 1990s, I would say that gays and lesbians that were out at the time are probably more educated in all aspects of sexual health than the general population. And this false sense of security is troubling given the fact that HIV infection rates are holding steady, especially due to a high rate of transmission among gay youths, particularly black gay youths.[2]

But with several countries already lifting their MSM blood donation deferrals entirely, perhaps we can generate enough scientific data to show the risks (or lack thereof) of lifting the ban at home. For a better understanding on the emergence of HIV/AIDS and the gay community's response, I would recommend David France's Oscar-nominated documentary, *How to Survive a Plague*, and HBO Film's adaptation of Larry Kramer's *The Normal Heart*.

Christopher Marin, a member of the bar publications committee, is a sole practitioner based in Riverside with a focus on family law. He is also Secretary for the Barristers 2014-2015 Board of Directors. He can be reached at christopher@riversidecafamilylaw.com

2 http://www.cdc.gov/hiv/pdf/statistics_basics_factsheet.pdf

Membership

The following persons have applied for membership in the Riverside County Bar Association. If there are no objections, they will become members effective January 30, 2015.

Angel Lee Coleman – Solo Practitioner, Riverside

Richard Crites – The Crites Law Firm, Temecula

Terry K. Davis – Law Offices of Terry K. Davis, Tustin

Alicia I. Dearn – Bellatrix PC, San Diego

Tiffany Ann Johnson – Shiraz Law Group, Long Beach

Joan Seguini Mountain (A) – Chapman University SOL, Orange

Jay Howard Robinson – Office of the U.S. Attorney, Riverside

Jeffrey R. Sissung – Holstrom Sissung & Block APLC, Corona

Nesa Targhibi – Solo Practitioner, Eastvale

Breanne N. Wesche (S) – Law Student, Houston TX

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Judicial Profile: Commissioner Eric Isaac

by Juanita Mantz

In October 2014, as Commissioner Eric Isaac walked in to begin his first day as a visiting Commissioner in Department 22 at the Riverside Superior Court, he knew his life had come full circle. Commissioner Isaac had been appointed a commissioner on October 24, 2013, after more than a year of serving as an AB 109 Hearing Officer dealing with realignment.

Commissioner Eric Isaac

Prior to his service as a hearing officer, Commissioner Isaac had worked for 15 years as a Deputy Public Defender at the Riverside County Public Defender's Office as both a trial attorney and a supervisor where he was well respected for his trial and supervisory skills. As Deputy Public Defender Supervisor Eric Keen states succinctly, "I've known Commissioner Isaac as a friend and as a colleague for over 17 years. As a defense attorney he was as tenacious as they come. As a member of the bench he has garnered the respect of all who appear in his court."

Commissioner Isaac's experience in dealing with clients as a deputy public defender for so many years has put him in good stead for dealing with the general public. "Dealing with so many clients for years as a public defender made dealing with pro per litigant clients a lot easier. Nothing shocks me," he said. He also has a long range of experience in dealing with the Evidence Code. "As a trial attorney, I did a lot of trials and became proficient at the Evidence Code, which helps when dealing with evidentiary hearings as a judicial officer." He went on to add, "What is interesting is that civil court can be much more confrontational at times, much more so than criminal."

Commissioner Isaac graduated from Southern Illinois University in 1990 and from American College of Law in 1996. After graduating from law school, he almost immediately started working at the Riverside County Public Defender's Office. The year was 1997 and as a newly appointed public defender, he was assigned to misdemeanors in Department 22. At the time, the Commissioner presiding over the department was Commissioner Becky Dugan (now Judge Dugan, the presiding judge over criminal courts). Commissioner Isaac reminisced that, "I would have never thought, back then in 1997, that one day I would be a judicial officer in that same department."

As he tells it, a wave of nostalgia rolled over him as he entered the courtroom in his black robe on his first day on the bench in Department 22 in October 2014 when he was asked to serve for two months to fill a short term vacancy. "You see," he told me as we sat down in his chambers in Department 2 at the Historic Civil Courthouse where he currently handles civil matters ranging from civil harassment, judgment debtor exams, and restraining orders to name and gender changes, "It was hectic in Department 22, the pace of it, but I loved it."

Commissioner Isaac will soon be dealing with a heavy calendar and hectic pace serving in Family Court in F201, where he will be handling all family court matters including, visitation, custody, and family support. "I volunteered for it," he said with a rueful grin. "Some people say I am crazy, but we shall see." "The best part is that I will get to handle a wide range of matters, everything from visitation to family support and custody issues."

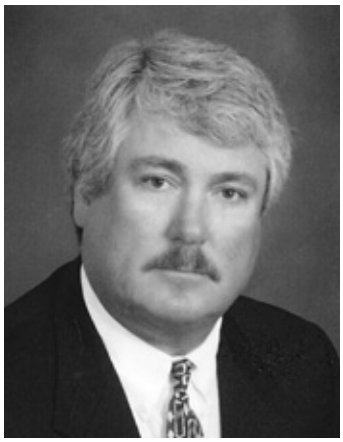
In his spare time, Commissioner Isaac enjoys spending time with his wife, who is a social worker in Los Angeles County, and their three children.

Juanita E. Mantz has been with the Public Defender's Office since 2009 and is currently assigned to Department 63 in Riverside defending felonies.

Opposing Counsel: William Weathers

by Bruce Todd

William "Bill" Weathers is, along with some of his cohorts such as Bill Shapiro, Tim Peach and Jeff Raynes, one of the "go to" homegrown plaintiff's personal injury attorneys in the Inland Empire.



William "Bill" Weathers

It wasn't always that way for Weathers who was raised in Loma Linda and attended La Sierra Academy in high school. There was a time when it appeared that his niche was going to be as a top flight insurance defense attorney. In fact, he successfully defended so many cases that, when he finally switched to the plaintiff's side, he continued to receive defense verdicts (to the detriment of his clients). It didn't take long, however, for him to reverse the trend and he has subsequently established himself as one of the very best plaintiff's personal injury attorneys in the Inland Empire.

"I lost my first few cases when I switched back to the plaintiff's side and some of my friends joked that I should have remained as a defense attorney," he reminisces.

Actually, Weathers started, somewhat unsuccessfully, his legal career as a plaintiff's personal injury attorney before making his transition to a well-respected defense attorney. He had been hired at Hayton & Peach in San Bernardino. Upon his arrival in court one day to assist Robert Peach for a trial, Peach said to him "why don't you pick the jury." The case was against the Orange County Flood Control District and it involved the drowning of a child. Weathers was in shock because he had never tried a case before. After Weathers picked the jury, Peach said to him that he should simply finish off the trial. Peach left Weathers on his own as he left to handle some other affairs at the firm. As can be expected, Weathers was not fully prepared for his first trial and he ended up losing it on a nonsuit.

"That was without a doubt my worst trial experience," he recalls. "The judge even pulled me aside to tell me not to say 'okay' after receiving a response from each witness."

His next case was a "dram shop" case against Lloyd's Restaurant in Running Springs and he again came out on the losing end.

In 1979, he bumped into his friend Jeff Raynes in court. Raynes was a member of the prominent insurance defense firm Thompson & Colegate in Riverside. Raynes told him that he was leaving Thompson & Colegate to join forces with legendary plaintiff's attorney Florentino Garza in San Bernardino and that there was now an opening at Thompson & Colegate. Weathers arranged for an interview with Don Brown and Art Kelly at Thompson & Colegate and, after he joined them for an interview which he describes as more of a "wet lunch," he was hired as a defense attorney. He commenced his employment there around the same time as John "Jack" Marshall and Bruce Bailey.

It didn't take long for Weathers to develop superb trial skills with the assistance of Brown, Kelly and other experienced firm members including Leighton Tegland and Don Grant. During his tenure at Thompson & Colegate, he tried close to 20 cases and obtained defense verdicts on almost all of them. Some of the cases involved high pressure wrongful death cases including one that he particularly remembers when a little girl was killed when she darted out into the street.

Back at the Hayton & Peach front, Arthwell Hayton had left the firm. Bob Peach had added his son, Tim, Tim's friend, and Bill Shapiro, a law school classmate, to form Peach, Shapiro & Peach. Then Shapiro left to start his own firm and Bob Peach encountered serious health problems. Tim Peach needed immediate help. He contacted Weathers, whom he first met when they were 10 years old at summer camp and then reconnected with while they were together in law school, to ask him whether he wanted to give plaintiff's work another try. Now that he had successfully honed his trial skills, Weathers decided to jump ship from Thompson & Colegate in 1985 and he agreed to join his old buddy Peach. The law firm eventually morphed into Peach & Weathers which is now one of the most respected plaintiff's personal injury firms in the Inland Empire.

Weathers and Tim Peach have obtained numerous high dollar verdicts in favor of their clients. They recently teamed with Raynes, who is regarded as one

of the top medical malpractice attorneys in California, to obtain a near $5,000,000 verdict.

Given the sometimes unique factual nature of Weathers' cases, some of them have concluded with unusual, and even tragic, results.

"I remember that we sued a psychiatrist for having a sexual affair with his patient," he recalls. "In fact, he was having affairs with numerous patients. Shortly after we filed the lawsuit, he committed suicide."

Weathers is extremely complimentary of his friend Peach.

"Everybody loves Tim because he is so easy going," he notes. "We are kind of opposites. I am Type A and he is calm and relaxed. In 30 years, we have never really had an argument. We play golf and vacation together. He is wonderful person to bounce off ideas. He is really my best friend as well as my partner."

In fact, Weathers' connection to the Peach family resulted in a somewhat indirect way to Weathers' now long time marriage to his wife Terri.

"I introduced Art Hayton (Terri's father) to his then wife," says Weathers. This was in 1980 and I was invited to his wedding where I first met Terri. She became a nurse and, ultimately, an attorney and I ran into her one day in 1987 while she was working at Thompson & Colegate. I was there for a deposition and I asked her to go out on a date. We eventually got married in 1988."

Any conversation with Weathers would not be complete without reference to his brother the Honorable Doug Weathers (retired). When Bill Weathers graduated from Western State College of Law in 1977, his brother commented to him that, "if you can do it, then how hard can it be." Judge Weathers enrolled in law school in 1978 and eventually became a very well-respected plaintiff's personal injury in his own right. In fact, he actually worked together with his brother and Tim Peach for three years before he was appointed to the Riverside County bench.

"We were friendly brotherly competitors for a number of years before he joined our law firm," Weathers says of his brother. "He was a wonderful asset and a tireless worker. Doug was very detail oriented and had a great work ethic."

Judge Weathers went on to become one of the more respected judges on the Riverside County bench. Sadly, due to health reasons, Judge Weathers had to retire from the bench in 2010. Weathers and his wife share a vacation home in Newport Beach with Judge Weathers and his family. Weathers, who lives in Riverside, tries to spend as much time as possible visiting with his brother. Weathers also has a vacation home in Puerta Vallarta where he and his family periodically vacation with his law partner Peach, who also has a nearby home.

Besides being a member of the Riverside County Bar Association, Weathers is also a member of the prestigious American Board of Trial Advocates (ABOTA). He served as local chapter president in 2000. He is also a member of Consumer Attorneys of California and the Association of Trial Attorneys of American. He is "AV" rated by Martindale-Hubbell.

For all of these reasons, he is definitely a "go-to" attorney for anyone who needs personal injury representation.

Bruce Todd, a member of the Bar Publications Committee, is with the firm Diederich & Associates in Redlands.

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