Lex and Verum

The National Association of Workers' Compensation Judiciary

Number V, 0110

Investigating Social Networking Web Site Pages

John P. Ratnaswamy, Esquire

As of July 2009, Facebook states that it has over 250 million active users. Numerous other social networking Web sites, such as MySpace, LinkedIn, and Friendster, also have large numbers of users in the United States and around the world. Hundreds of millions of people world-wide have personal pages on social networking Web sites. The pages often are private, but the user may grant reviewing privileges to others.

In a March 2009 advisory opinion, the Pennsylvania Bar Association Committee on Legal Ethics and Professional Responsibility addressed the subject of a lawyer's using a third person to obtain information on a user's Facebook and MySpace personal pages.

The opinion arises out of an inquiry, and assumes a set of facts. In brief, the inquiring lawyer believes that pages maintained on Facebook and MySpace by a non-party witness who was deposed in a civil lawsuit may contain information relevant to the lawsuit. The inquirer did not ask the user during the deposition for the contents of the pages or for permission to access them, but later checked and found that accessing the pages required the user's permission. The inquirer did not know if the user, if asked, would give the inquirer permission to access the pages, although the inquirer believed the user tends to freely grant access. The inquirer raised whether she or he ethically could ask a third person to request access to the pages, assuming the third person did not make any misrepresentation but did not disclose the purpose of the request.

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February "Second Fridays Seminar"

February 12, 2010

On February 12, 2010, the NAWCJ will present Jerry Fogel for a "Second Fridays Seminar." Mr. Fogel is the author of one of our articles this month, beginning on page 3, and his biography is on page 8. He has been a consultant to the Florida Department of Financial Services, Division of Workers' Compensation, and he has lectured extensively on workers' compensation. His presentation in February will be focused on the interaction between science and art in modern medicine. Topics will also include application of criteria to medical decisions. Join us by Webex or telephone. Contact President John Lazzara, JJL@NAWCJ.org for details.

NAWCJ Judicial College 2010:

The curriculum for the 2010 NAWJC Judicial College is being organized now. Do you have suggestions for topics or specific speakers? Please send your suggestions by email to Judge Lazzara JJL@NAWCJ.org, and make plans to join us. The 2010 NAWCJ College will be presented in conjunction with the Florida Workers' Compensation Institute (www.fwciweb.org) at the Marriott World Center (www.marriottworldcenter.com) in Orlando on August 15 through 18, 2010.

Investigating, from page 1.

That scenario is one instance of the very broad and complicated question of "deception in investigation," which can arise in a host of criminal and civil investigation contexts. The Pennsylvania bar committee analyzed three rules: Pennsylvania Rules of Professional Conduct 5.3 ("Responsibilities Regarding Nonlawyer Assistants"), 8.4 ("Misconduct"), and 4.1 ("Truthfulness in Statements to Others"). (Those rules are the Pennsylvania versions of similarly numbered and named American Bar Association Model Rules of Professional Conduct.) The committee also reviewed case law, including two well-known cases regarding deception in investigation: In re Pautler, 47 P.3d 1175 (Colo. 2002), and In re Gatti, 8 P.3d 966 (Or. 2000). (The Gatti case was followed by a change in Oregon's rules.) The committee also referred readers to two articles: B. Temkin, "Deception in Undercover Investigations: Conduct Based v. Status Based Ethical Analysis", 32 Seattle Univ. L Rev. 123 (2008), and D. Isbell & L. Salvi, "Ethical Responsibilities of Lawyers for Deception by Undercover Investigators and Discrimination Testers: An Analysis of the Provisions Prohibiting Misrepresentation under Model Rules of Professional Conduct", 8 Georgetown Journal of Legal Ethics 791 (Summer 1995).

The Pennsylvania bar committee concluded that, in the assumed scenario: (1) the inquirer would be responsible for the conduct of the third person under Pa. R. Prof. Cond. 5.3 (see also Pa. R. Prof. Cond. 5.1 ("Responsibilities of Partners, Managers and Supervisory Lawyers"))(the Pennsylvania version of another ABA Model Rule); (2) "the proposed course of conduct contemplated by the inquirer would violate Rule 8.4(c) because the planned communication by the third party with the witness is deceptive." (and that it also would violate Rule 8.4(a)); and (3) "the proposed conduct constitutes the making of a false statement of material fact to the witness and therefore violates Rule 4.1 as well". The committee, in discussing Rule 8.4(c), distinguished "the common—and ethical—practice of videotaping the public conduct of a plaintiff in a personal injury case to show that he or she is capable of performing physical acts he claims his injury prevents," The committee, in addressing Rule 4.1, discussed the citations above regarding deception in investigation, noting the controversial nature of that subject.

The committee noted but did not offer a conclusion on the question of whether the assumed scenario would constitute a violation of P. R. Prof. Cond. 4.3 ("Dealing With Unrepresented Person") (the Pennsylvania version of another ABA Model Rule). The committee also declined to address, as beyond the scope of its charge, the question of the admissibility of any information that would be obtained by the third person.

John Ratnaswamy is a partner in the Chicago office of Foley & Lardner LLP. He also serves as an Adjunct Professor of Legal Ethics at the Northwestern University School of Law. John is a former member of the American Bar Association's Standing Committee on Ethics and Professional Responsibility. This column should not be understood to represent the views of any of those entities or the firm's clients.

For an example in the news: http://tech.yahoo.com/blogs/null/156288;_ylt=Arq5OkQDjfNEADenyLXVrajxMJA5

This article, reprinted with permission from the American Inns of Court and John P. Ratnaswamy, was published in the September/October 2009 issue of The Bencher, a bi-monthly publication of the American Inns of Court.

American Inns of Court

Judges can lead the way to more professional practice. One proven vehicle is the American Inns of Court (AIC), which are designed to improve the skills, professionalism and ethics of the bench and bar. An American Inn of Court is an amalgam of judges, lawyers, and in some cases, law professors and law students. Each Inn meets approximately once a month both to "break bread" and to hold programs and discussions on matters of ethics, skills and professionalism. The American Inns of Court adopted the traditional English model of legal apprenticeship and modified it to fit the particular needs of the American legal system. American Inns of Court help lawyers to become more effective advocates and counselors with a keener ethical awareness. Members learn side-by-side with the most experienced judges and attorneys in their community.

Two Inns of Court are dedicated to the workers' compensation practice. They are:

Justice James H. Coleman Jr. New Jersey Workers' Compensation American Inn of Court

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FWCI: http://www.fwciweb.org/index.html

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The Art and Science of Medicine: A Judicial Dilemma or *Criteria*-Based Medicine: A Practical Approach For Making Determinations

By Jerry Fogel,
PT, MS, CHCQM

Medical decision-making has come under great scrutiny of late and with good reason. With all the attention health care reform is getting, it now seems widely accepted that clinical decisions are often more a function of referral, authorization and reimbursement patterns, fear of litigation, and patient preference/expectation, rather than the appropriate relevant clinical criteria.

It is understandable then why the relatively recent advent of evidenced-based medicine (EBM) has been lauded by its supporters as the savior of clinical practice based on its reliance on published research and the use of "*science*" as a basis for decision-making. It would seem logical that this would be a real boon for judges as well who routinely rely on medical testimony and documentation to make determinations and rulings in a legal setting. Although there is merit in both these statements, like most things in life, it is not quite that simple.

EBM is not without its detractors. There are those who believe that the limits of current science given the paucity of high-quality, relevant clinical research, the presence of politics and bias in much of the research itself, and the misapplication of the findings by both providers and consumers are all major concerns in need of consideration. Again, there is much merit in these statements as well.

Clearly, this poses a significant dilemma for adjudicators as they are again called upon to be referees in a system seemingly without rules. To make matters worse, the medical community then in turn often blames the legal system for diluting or abusing "medical science and facts" in their rulings. Is there then a responsible, rational basis for making medical, and in turn, medico-legal determinations?

What follows is a two part effort to thoughtfully address that question. First, a brief but candid discussion of both EBM and current, real-world medical decision-making will be outlined. Second, a practical, rational model for making both clinical and corresponding medico-legal determinations will be offered.

EBM, in its modern day incarnation, has been initially attributed and most notably advanced by medical scholars such as Cochrane, Sackett, Guyatt, and others. To wit, Sackett's definition is probably the most widely accepted;

> *"the practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research."* [1]

It should not go unnoticed that even in its purest definition, the founders of the movement are acknowledging that it is not a two dimensional process. That one must integrate (i.e. thoughtfully apply) the facts of the specific case along with the clinicians experience, skill and judgment all to the best available relevant research.

The good news is that this has resulted in a renewed effort toward clinical efficacy research and the development of numerous clinical practice guidelines. These publications are typically created through a professional consensus process aimed at distilling the available research through a vetting process for quality, applicability and other criteria, and then formulating practical guidelines for clinical decision-making.

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Meet Your Board:

Chief Judge Paul M. Hawkes is originally from Connecticut. He was appointed to The Florida First District Court of Appeal by Governor Jeb Bush on January 2, 2003. Judge Hawkes received his BS Cum Laude from University of South Florida in 1983 and his Juris Doctor with Honors from Florida State University in 1985. Prior to his appointment to the Bench, he served in the Air Force for three years, was an Assistant State Attorney, 5th Judicial Circuit, State of Florida (1986-1988), State Representative, Florida House District 26 and District 43 (1990-1994), member of the Florida Constitutional Revision Commission (1997/1998), worked in the Office of Policy & Budget, Executive Office of the Governor (2000), and was the Chief of Policy, Florida House of Representatives (2000-2002). He also worked in private practice with Rumberger Kirk Caldwell Cabinas & Burke PA (1986), and in Private practice, Crystal River Florida (1988-2000).

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2010 Program will include:

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James N. McConnaughhay, Esq
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The Art and Science of Medicine, from Page 3

The bad news is the too often unrealistic expectation that there is an "ultimate truth" about most things medical, including clinical practice guidelines, creating a false sense of black and white reality.

Seemingly, the consumers, in the form of patients, employers, carriers, and the legal community, are faced with a (false) choice between "cookbook medicine and the tyranny of research" and the unfettered "expertise and clinical experience" of the treating practitioner. The choice is false because the two are not mutually exclusive; each has a role in the delivery of quality medical care.

Sackett's own analysis may be the most balanced about the mutual dependency the two variables:

> "Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough. Without clinical expertise, practice risks becoming tyrannized by external evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without current best external evidence, practice risks becoming rapidly out of date, to the detriment of patients."[2]

Years earlier, but consistent with Sackett's perspective, when addressing the debate between the art and science of medicine for my students, I offered my own definition:

> "The science of medicine is the consistent and deliberate ability to reproduce the art." [3]

More specifically, the framework for accomplishing that balance broadens the focus from the narrow cast of the exclusive domain to narrowly structured research to the broader application of relevant criteria for defining and differentiating. This has been coined the criteria-based model (CBM)[4] and has shown to be an academically honest and eminently more practical approach to integrating responsible science into the medical determination process. Thus, CBM does not supplant the art of medicine, but combines the responsible science into that art for a more responsible approach based on both. Although it is beyond the scope of this article to address the entirety of CBM, there are some fundamental components that are critical to this topic and therefore require further discussion.

The first issue to be addressed is that of defining first whether the determination being made or question being asked is even the correct one. I submit this is ultimately the most critical factor in assuring appropriateness of decision-making. To structure the discussion, using the CBM, I have developed a seven (7) fundamental determination framework in the medical disability sphere, especially in workers compensation:

1. Is there an illness or injury?
2. If so, what is the specific nature (diagnosis/problem identification)?
3. Is there any reason to think (from a medical perspective) that the illness/injury is not work related?
4. Is treatment required and if so, what?
5. Are there any functional restrictions/limitations, and if so, what?
6. Do the aforementioned functional restrictions/limitations impact on the injured workers specific job? If so, what accommodations can be made?
7. What is the prognosis and related determinations? (i.e. discharge, MMI, impairment ratings, future medical indications, etc).

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Each of the above questions has its own unique, relevant, and pre-defined criteria that must be used in the analysis and determination process. In addition, and maybe even more importantly, they must be answered sequentially as each is prerequisite to the subsequent determinations.

For example, to determine if someone is ill or not, a responsible confirmation process requires the identification of some disturbance in physiology (biological function). This is standard in most aspects of medicine, but seems to be all too often missing as the standard in workers compensation, especially in musculoskeletal problems such as low back pain. In workers' comp, all too often determinations are made on subjective complaints (symptoms) alone, thereby not even reaching the minimum threshold of confirming the presence of actual illness. It is important to understand that the mere presence or absence of symptoms and/or pain alone does not accurately represent the presence, absence or severity of an ailment. In other words, an individual can have pain and no illness, have an illness with no pain or other symptoms, and almost every other possible pattern in between. Pain is a unique emotional experience and is not a biological sensation in the purest sense. Therefore it must always be correlated with some measurable disturbance of the underlying system (physiology) in question. Examples could include, fever, swelling and other signs of inflammation or tissue irritation, neurological signs such as motor, sensory or reflex changes, abnormal joint mechanics, and the more traditional lab studies such as blood /urine analysis or ECG testing.

The same is true for abnormal anatomy (structure), such as routinely shown on imaging studies (i.e. x-ray, CT, MRI). One can have extensive abnormal anatomy without manifesting other symptoms or and dysfunction, and visa-versa. The classic examples are herniated lumbar discs (spine) and prolapsed mitral valves (cardiac), where these abnormalities are found in equal to superior numbers in the healthy population as compared to the clinically ill/injured population.

Therefore, pain and/or abnormal anatomy, in the absence of confirmed abnormal relevant exam findings (physiology) should be questioned aggressively as a basis for confirming or clarifying and illness or injury.

Each item on the list has a corresponding set of relevant criteria. Another example is functional restrictions. This determination should be based on whether the activity is likely to worsen the condition or delay recovery, and ***not*** on whether it aggravates the symptoms (which treatment often does as a natural part of the healing and recovery experience). In other words, there is a critical distinction between hurt (increase in symptom) and harm (worsen the condition). For example, a responsible clinician would not forego physician therapy to rebuild muscle and increase function just because it is uncomfortable (hurt), but likewise would forego such therapy if it were actually detrimental to the patient (harm). This distinction is obvious in the treatment illustration, but often overlooked in the return-to-work analysis.

Another factor is the sequential or prerequisite nature of the elements. As one reviews the list, it should become self-evident that a specific diagnosis (#2) cannot be determined unless and until there is confirmation of objective, relevant findings (#1) denoting a health disturbance. How can one determine if an injury (or portion thereof) is work related (#3) until an injury is confirmed and defined. Any treatment (#4) would clearly depend on the above three determinations, including for example, item #3 in terms of is the entire underlying condition compensable or just the exacerbation? Functional restrictions/limitations (#5) are often affected not only by the illness but by the treatment (#4) itself (immobilization, medications, etc). Item #6, the vocational impact (as determined by the employer, and therefore the ***only*** non-clinician determination on the list) is based exclusively on the functional restrictions/limitations (#6), and not, as is often done in practice (incorrectly), on the illness (#1 & #2). And of course, prognosis (#7) is the gestalt issue based on all the factors and therefore is the final determination.

Therefore, the principle consumer (ultimately unfortunately too-often judicial) framework is to ensure that the medical evidence being offered is used to address the appropriate question, and in the appropriate order, so as to assure that each item is determined on the merits, and uses relevant criteria. The good news from practical standpoint is that this is where the overwhelming majority of disputed or litigated issues arise and can be resolved.

The final discussion is on the far less frequent, but somewhat challenging issue of weighing medical research or science when the veracity of a determination, procedure, or application issue is in dispute. A detailed analysis of this topic, and a specific model for the rational, responsible *integration* of research and science into the clinical and medico-legal determination process has already been documented by this author [5] and the reader is encouraged to review for a more detailed discussion. That said, a brief summary of the key points are offered below.

In general, in order to make a determination: a clinician (or judge) must filter the facts of the case through the twin criteria of relevant statute, regulation, and case law and medical and related science. The key is in the application. One must first accurately establish the facts of the case (physiologic findings, accident investigation, medical history, etc), then assess how they square with the legal requirements and definitions, as well as the tenets of basic science (anatomy, physiology, etc) and clinical research (epidemiology, efficacy studies, etc).

Therefore, in order to have faithful compliance of all parties to this intention, a comprehensive and integrated approach must be taken in regards to EBM or it will create more problems that it resolves. For example, successful application of EBM requires that:

- The statute and regulations establish a policy of support for, and a deference to, determinations based on science and clinical research, as well as clear and practical definitions, criteria and rules of engagement for applying EBM.
- Physicians and other clinician providers are given incentives via referral, authorization and reimbursement enhancements, given proper and ongoing education and training, and responsible clinicians and their decisions are supported in the dispute and litigation process.

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- Employers and carriers must utilize the same information and criteria in their decisions regarding referrals, authorizations, and reimbursement practices, administrative work flow, work/duty status and other related disability determinations.
- The legal system must adjudicate medically-related disputes using the same information, i.e. based on the relative merit (strength and applicability of the evidence) of the relevant clinical variables in question, and not on the credentials of the practitioners, the behavior of the participants, or as a compromise or based on other irrelevant criteria.

Therefore, a conceptual model that is both practical and academically honest is required. The following model accounts for all three aspects of responsible criteria-based clinical practice and provides a fundamental framework for utilization.

- There should be a deference to the treating practitioners, therefore, recommendations and requests for evaluation, diagnostic testing, and/or treatment should be routinely approved unless there are specific, relevant, merit-based reasons to question or deny authorization (i.e. requested service is clearly not necessary, appropriate, or additional information or clarification is required). This same deference should be applied in dispute resolution in that, given essentially equal levels of documentation and support for either side of a dispute between the treating clinician and a consulting clinician, the treating clinician would be given deference.
- All parties, including, but not limited to, physicians and other relevant clinicians, employers, injured workers, carriers, medical case managers and advisors, medical networks, attorneys, Judges, and even regulators and legislators should make all attempts to make medical and related decisions and determinations based on the merits of the issue utilizing evidenced-based medicine. A criteria-based hierarchy is outlined, in descending order, below:
    - Specific Research Support
      Specific, relevant, scientific studies published in widely-respected juried journals (i.e. random controlled trials (RCT), systematic reviews of controlled trials).
    - Professional Consensus
      Integrating science and practice (i.e. evidenced-based practice guidelines or other relevant position papers from respected organizations such as ACOEM, ODG, AAOS, AHRQ, etc).[6]
    - Principle-based (inherent logic)
      Established and well-defined clinical reasoning applied to relevant anatomical, physiological, pathological, and clinical principles. Case-specific data (objective, relevant exam findings), outcomes and measures should be utilized for accountability.

In summary, the more defined the question, the more relevant the criteria, the more factual the case, the more predictable, appropriate and fair the determination. After all, surgery should only be authorized when a patient has been confirmed to have a substantive illness and that specific surgical procedure been shown to be an effective treatment in relation to that illness, and not because the physician or attorney advocating the procedure was more articulate, or that their judge did or did not believe in the procedure.

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Interesting Pro-Se Litigant Resources

Meeting the Pro-se challenge, by Kathleen M. Sampson, American Judicature Society
http://www.ajs.org/prose/pro_sampson.asp

Self-Representation Resource Guide, National Center for State Courts
http://www.ncsconline.org/wc/CourTopics/ResourceGuide.asp?topic=ProSe

Pro Se Litigation: Best Practices from a Judge's Perspective, University of Richmond Law Review, The Honorable Beverly W. Snukals, and Glen H. Sturtevant, Jr.
http://lawreview.richmond.edu/?p=538

Pro Se policy recommendations from the American Judicature Society
http://www.ajs.org/prose/pdfs/Policy%20Recom.pdf

Wikipedia
http://en.wikipedia.org/wiki/Pro_se_legal_representation_in_the_United_States

SelfHelpSupport.org
http://www.selfhelpsupport.org/

Michigan Executive Order Shrinks Board

Michigan Governor Jenifer Granholm issued Executive Order 2009-53 on October 29, 2009. The Order reduces the Michigan workers compensation Board of Magistrates from 26 members to 17 effective January 26, 2010.

http://www.michigan.gov/documents/wca/wca_EXEC_ORDER_2009-53_299202_7.pdf

Coming in February

Details about the 2010 NAWCJ College
The Friends of 440
Perspective on Professionalism

From Workcompcentral.com:

Department Appeals Decision Saving Comp Judges' Jobs:

The Missouri Department of Labor and Industrial Relations is appealing a decision by a Cole County circuit court judge that the jobs of three administrative law judges who decide workers' compensation cases cannot be eliminated as part of state budget cuts.

Judge Jon Beetem issued a permanent injunction Sept. 9 that preserved the judges' jobs and also prohibited the state from retaliating against the judges. Beetem ordered the state to pay nearly $40,000 in legal fees for the judges. The judge issued a temporary order in July which halted the effort to terminate the judges' positions.

Department spokeswoman Amy Susan told WorkCompCentral in September that the department is appealing Beetem's decision to the Missouri Court of Appeals, Western District.

A court date has yet to be assigned, Susan said.

The department planned to eliminate five judges' positions as of June 30. One of the judges was retiring and another obtained employment elsewhere. Three judges went to court.

Gov. Jay Nixon (D)'s administration said the judges were being dismissed because of budget cuts approved by the Legislature. The judges argued they could be removed only for poor performance and not as a cost-saving measure.

Attorney John Comerford, who represented judges Henry Herschel, Matthew Murphy and John Tackes, said the court decision makes it clear that workers' compensation judges cannot be removed by cutting the state budget.

The three judges were appointed by former Gov. Matt Blunt, a Republican. Herschel was Blunt's general counsel.

In his ruling, Beetem said that administrative law judges can be removed only when their terms have expired or by the governor after at least two votes of "no confidence" by a review committee.

Beetem said "the termination of one's appointment as an administrative law judge, prior to the expiration of his term and without reliance upon the statutory process, violates one's right to procedural due process."

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Consistent application of the process outlined will result in consistent evidence based decisions by clinicians, adjusters, employers, and ultimately Judges. Clinical expertise is crucial and indispensable, but the conclusions and decisions made by the clinician must be supported by the science, e.g. "the best available external evidence." After all, "in God we trust…all others bring data!"

References:

1. Sackett, DL (1996)."Evidence based medicine: what it is and what it isn't." BMJ 312 (7023): 71–2
2. Sackett, DL (1996).Evidence-based medicine. *Seminars in Perinatology*, Volume 21, Issue 1, Page 3-5
3. Fogel, JN (1981). Northwestern University Medical School, Programs in Physical Therapy
4. Fogel, JN (2001) Workers Compensation Reform Proposal, State of Florida
5. Fogel, JN, et al (2007) Three Member Panel Biennial Report, Division of Workers.
6. American College of Occupational and Environmental Medicine (ACOEM), Official Disability Guidelines (ODG) of the Work Loss Data Institute, American Academy of Orthopedic Surgery (AAOS), Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services.

Mr. Fogel is a clinician, educator, and consultant, and is principle and President of *Imagine Clinical*, a healthcare consulting firm, with a special emphasis in Workers' Compensation, serving all industry stakeholders including employers, insurers, the medical community, and government officials and agencies. A veteran of the healthcare industry for over three decades, he has had a broad range of experiences and accomplishments, most noted for his innovative approach. A long time consultant to the State of Florida, Jerry was one of the key architects of the 2003 WC reforms, including key medical provisions and the creation of the precedent-setting universal DWC-25 form. Previously Mr. Fogel was the Director of the Orthopedic PT Graduate Program at Northwestern University Medical School, and has been visiting professor at Medical, Chiropractic, Podiatry and PT schools. He also served as the Clinical Director of a WC Insurance Company. His innovations are many including the establishment of one of the first telephonic nurse case management programs for WC in the country and, more recently, the establishment of a criteria-based model for managing injured workers that has been adopted with unprecedented success by major employers, insurance carriers and the medical community. Mr. Fogel started his career as a practicing clinician, having received his BS in Physical Therapy from SUNY Downstate Medical Center, an Advanced MS in Orthopedic Physical Therapy from Northwestern University, and is a Diplomate of the American Board of Quality Assurance and Utilization Review Physicians (ABQAURP).

Why Can't We Be "Friends?"

The Short answer is the Code of Judicial Conduct ("CJC") says so. The Judicial Ethics Advisory Committee ("JEAC") of the Florida Supreme Court issued JEAC-20 on November 17, 2009. The JEAC is charged with rendering advisory opinions interpreting the application of the CJC to specific circumstances confronting or affecting a judge or judicial candidate.

JEAC opinions are advisory to the inquiring party, to the Judicial Qualifications Commission ("JQC") and the judiciary at large. Conduct consistent with a JEAC opinion may be evidence of good faith on the part of the judge, but the JQC is not bound by the interpretive opinions by the JEAC.

JEAC-20 concludes that a judge may post comments and other material on the judge's page on a social networking site, if the publication of such material does not otherwise violate the CJC. However, a judge may not add lawyers who may appear before the judge as "friends" on a social networking site, nor may the Judge permit such lawyers to add the judge as their "friend." The Committee explained:

> in order to fall within the prohibition of Canon 2B, the Committee believes that three elements must be present. First, the judge must establish the social networking page. Second, the site must afford the judge the right to accept or reject contacts or "friends" on the judge's page, or denominate the judge as a "friend" on another member's page. Third, the identity of the "friends" or contacts selected by the judge, and the judge's having denominated himself or herself as a "friend" on another's page, must then be communicated to others

The JEAC also noted this restriction applies only to websites where the judge is involved in the selection of the individuals whose names appear within the group on the site, or such sites where the judge has the right to approve or reject the lawyer being listed on the site.

JEAC-20 also addresses the conduct of "a committee of responsible persons" that is conducting an election campaign on behalf of a judge's candidacy, concluding such a committee may post material on the committee's social networking page as long as that material does not otherwise violate the CJC. Such a committee may allow people the option to "list themselves as fans or supporters" of the judge's candidacy as long as the Judge or committee does not control who is permitted to list himself or herself as a supporter.

The full text of the opinion is available at:
http://www.jud6.org/LegalCommunity/LegalPractice/opinions/jeacopinions/2009/2009-20.html

All of the Florida JEAC opinions are available at
http://www.jud6.org/LegalCommunity/LegalPractice/opinions/jeacopinions/jeac.html

Much attention has focused on this. South Carolina has also addressed the issue. See:
http://news.google.com/news/story?ncl=http://network.nationalpost.com/np/blogs/legalpost/archive/2009/12/14/facebook-rules-for-judges.aspx&hl=en

WE NEED *YOU*, YOUR *WRITINGS*, YOUR *IDEAS*

Do you write about topics that would be of interest to our members? Have you entered a decision in which Judges around the country would be interested? The NAWCJ communicates monthly with more than 600 workers' compensation adjudicators and appellate review officials across the country. If you have ideas for articles or would like to submit a case note or article, contact Hon. John Lazzara at JJL@NAWCJ.org

Thanks to our NAWCJ 2010 Judicial College Curriculum Committee:

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Workers' Compensation Resources

Work Comp Central
www.workcompcentral.com

Workers' Compensation Service Center
www.workerscompensation.com

Judge Tom Leonard, Oklahoma
judgetom.blogspot.com/

Judge David Torrey, Pennsylvania
www.davetorrey.info/works.htm

National Association of Workers' Compensation Judiciary
www.NAWCJ.org

Florida Workers' Compensation Institute
www.FWCIweb.org

National Institute of Occupational Safety and Health
http://www.cdc.gov/niosh/

Membership in the National Association of Workers' Compensation Judiciary is open to any person whose responsibility is the adjudication of workers' compensation claims. Throughout the nation, there are a variety of titles that are used to describe us, "Judge," "Commissioner," "Deputy Commissioner," "Referee," and "Hearing Officer" are a few. The NAWJC also has Associate Membership for those interested in supporting the education of workers' compensation adjudicators. The NAWJC is thankful to the concerned professionals that have contributed their time and resources to support our efforts. We recognize them here.

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February 12, 2010 Jerry Fogel, "Medicine, Disability, & Liability."

April 9, 2010. Robert Pass, Carlton Fields, Issues Involving Electronic Discovery and Electronic Records.

May 14, 2010. Dr. Charles Geraci, Center for Disease Control, NANOTECHNOLOGY – A "TINY" PRIMER ON ISSUES.

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