



5-26-1976

## Report of Seminar on Law and Medicine

Office of Continuing Legal Education at the University of Kentucky College of Law

Charles M. Leibson  
*Jefferson Circuit Court*

John A. Krichbaum  
*American Medical Association*


Paul A. Van Pernis  
*American Medical Association*

William C. Ball  
*Ball and Nagel, P.C.*

*See next page for additional authors*

**[Click here to let us know how access to this document benefits you.](#)**

Follow this and additional works at: [https://uknowledge.uky.edu/uky\\_cle](https://uknowledge.uky.edu/uky_cle)

 Part of the [Health Law and Policy Commons](#), [Law and Psychology Commons](#), [Medical Jurisprudence Commons](#), and the [Torts Commons](#)

### Repository Citation

Office of Continuing Legal Education at the University of Kentucky College of Law; Leibson, Charles M.; Krichbaum, John A.; Van Pernis, Paul A.; Ball, William C.; White, Galen J.; Peterson, Harry N.; Anderson, B. J.; Ruben, Harvey L.; Weitzel, William D.; Bruton, Oliver Grant Jr.; Barber, Oliver H. Jr.; Savage, Joe C.; Turnley, Robert J.; Winter, William G.; Grant, L. T.; Grubbs, William D.; Landrum, Charles Jr.; Whitmer, Leslie G.; Rich, Robert; and Rothschild, Edward A., "Report of Seminar on Law and Medicine" (1976). *Continuing Legal Education Materials*. 16.  
[https://uknowledge.uky.edu/uky\\_cle/16](https://uknowledge.uky.edu/uky_cle/16)

---

**Authors**

Office of Continuing Legal Education at the University of Kentucky College of Law, Charles M. Leibson, John A. Krichbaum, Paul A. Van Pernis, William C. Ball, Galen J. White, Harry N. Peterson, B. J. Anderson, Harvey L. Ruben, William D. Weitzel, Oliver Grant Bruton Jr., Oliver H. Barber Jr., Joe C. Savage, Robert J. Turnley, William G. Winter, L. T. Grant, William D. Grubbs, Charles Landrum Jr., Leslie G. Whitmer, Robert Rich, and Edward A. Rothschild

# Report of Seminar on Law and Medicine—1976

May 26-28, 1976



Presented by the  
OFFICE OF CONTINUING LEGAL EDUCATION  
UNIVERSITY OF KENTUCKY COLLEGE OF LAW

In cooperation with the  
KENTUCKY BAR ASSOCIATION



SEMINAR ON  
LAW AND MEDICINE--1976  
MAY 26-28, 1976

PRESENTED BY  
OFFICE OF CONTINUING EDUCATION  
COLLEGE OF MEDICINE  
UNIVERSITY OF KENTUCKY

DR. FRANK R. LEMON  
DIRECTOR

AND

OFFICE OF CONTINUING LEGAL EDUCATION  
COLLEGE OF LAW  
UNIVERSITY OF KENTUCKY  
JOHN K. HICKEY  
DIRECTOR

PREPARED BY THE OFFICE OF CONTINUING LEGAL EDUCATION

JOHN K. HICKEY  
DIRECTOR

ROBERT W. GRIFFITH  
EDITOR & PUBLICATIONS MANAGER

JOYCE L. HUNT  
ADMINISTRATIVE ASSISTANT

PATRICIA G. MCCLAIN  
PUBLICATIONS SECRETARY

J. RICHARD DOWNEY  
RESEARCH ASSISTANT

THE EDITED TEXT OF THIS REPORT MAY VARY SLIGHTLY FROM THE  
PRESENTATIONS ACTUALLY DELIVERED BY EACH SPEAKER.

COPYRIGHT, FEBRUARY 1977

OFFICE OF CONTINUING LEGAL EDUCATION

UNIVERSITY OF KENTUCKY

LEXINGTON, KENTUCKY

# TABLE OF CONTENTS

	PAGE
<u>MALPRACTICE ISSUES</u>	
RECENT LEGISLATIVE ENACTMENTS	
HONORABLE CHARLES M. LEIBSON . . . . .	1
ARBITRATION AND OTHER ALTERNATIVES	
JOHN A. KRICHBAUM, J.D. . . . .	7
RISK CONTROL	
PAUL A. VAN PERNIS, M.D. . . . .	15
A PLAINTIFF'S LAWYER VIEWS MALPRACTICE	
WILLIAM C. BALL, J.D. . . . .	19
A DEFENDANT'S LAWYER VIEWS MALPRACTICE	
GALEN J. WHITE, J.D. . . . .	27
<u>GOVERNMENT BY REGULATION</u>	
AGENCY REGULATION, LAW AND THE PROFESSIONS IN 1976	
HARRY N. PETERSON, J.D. . . . .	37
UNJUSTIFIED REGULATION. WHAT RECOURSE? WHAT RESPONSE?	
B.J. ANDERSON, J.D. . . . .	45
REGULATORY IMPACT ON MALPRACTICE HAZARDS, CONFIDENTIALITY, CLINICAL DECISION MAKING, OTHER PHYSICIAN/PATIENT RELATIONSHIPS	
HARRY N. PETERSON, J.D. JOHN A. KRICHBAUM, J.D. B.J. ANDERSON, J.D. . . . .	57
<u>THE MENTALLY ILL - PUBLIC PROTECTION AND PATIENT RIGHTS</u>	
PSYCHIATRIC/LEGAL CONCEPTS OF DANGEROUSNESS	
HARVEY L. RUBEN, M.D., M.P.H. . . . .	65
CIVIL COMMITMENT OF THE MENTAL PATIENT	
WILLIAM D. WEITZEL, M.D. . . . .	77
MALPRACTICE HAZARDS IN PSYCHIATRY	
OLIVER GRANT BURTON, J.D. . . . .	89
PROTECTED RIGHTS OF MENTAL PATIENTS	
OLIVER H. BARBER, JR., J.D. . . . .	101

PERSONAL INJURY LITIGATION

STATEMENT OF THE FACTS OF THE CASE . . . . . 115

JOE C. SAVAGE, J.D. . . . .

DIRECT EXAMINATION OF MEDICAL EXPERT WITNESS

ROBERT J. TURLEY, J.D.  
WILLIAM G. WINTER, M.D.  
HONORABLE L.T. GRANT

CROSS-EXAMINATION OF MEDICAL EXPERT WITNESS

WILLIAM D. GRUBBS, J.D.  
WILLIAM G. WINTER, M.D.  
CHARLES LANDRUM, JR. J.D. . . . . 116

BUSINESS AND LAW IN THE PROFESSIONAL FRAMEWORK

PROFESSIONAL ETHICS AND ADVERTISING . . . . . 123

LESLIE G. WHITMER, J.D. . . . .

THE PROFESSIONAL SERVICE CORPORATION - PROS AND CONS

ROBERT RICH, J.D. . . . . 135

ESTATE PLANNING FOR THE PROFESSIONAL

EDWARD A. ROTHSCHILD, J.D. . . . . 149



## RECENT LEGISLATIVE ENACTMENTS

Honorable Charles M. Leibson  
Jefferson Circuit Court  
Louisville, Kentucky

There were three different pressure groups that were involved in recent Kentucky malpractice legislation. The first was the physicians. Physicians in the state of Kentucky were alarmed last year and the year before by the availability and the rising cost of medical malpractice insurance. This was a crisis brought down on the state of Kentucky, but not by the experience of the physicians in the state insofar as suits against them and pay-outs on those suits are concerned. The Governor's committee has statistics on this, so that I'm not just expressing a personal opinion when I say that problems elsewhere have caused carriers to increase the cost of insurance in Kentucky as well as to quit writing policies. Nevertheless, the problem is as real to the physicians that are involved as if it were one of their own making. Such problems have been dealt with in the Act in a manner that should be most helpful to physicians.

To some physicians, however, the main problem is being sued. The problem of being sued subdivides into groundless suits and meritorious claims where someone has been injured as the result of negligence by the physician or hospital or medical service provider, and is entitled to fair and reasonable compensation for the injury. There were a great many different proposals offering solutions. One involved eliminating all claims, groundless or meritorious. The legislature in Kentucky did not succumb to the pressure in that respect, nor did the Governor, who, as all of us know, had a very strong hand in what took place in the state legislature this past January.

Attorneys were also a pressure group. The attorneys had a responsibility, or if you want to consider it from an economic standpoint, a selfish interest in maintaining the right for suits to be brought when there is a meritorious claim. The attorneys have no more right to maintain groundless suits than you have to object to meritorious ones. Attorneys have considerable problems, however. The cost of malpractice litigation is very high. The persons who are potential claimants in many cases are suffering catastrophic injury, are totally unemployed, or are deceased. There's very little money available to finance the depositions, expert witness fees, and extensive trial procedure. There is also a great deal of unnecessary and, I believe, undeserved and perhaps unavoidable hostility that attorneys who take such cases experience which causes many attorneys to refuse to take such cases altogether. When I was practicing, they used to say, "Go see Charles Leibson; he'll take any kind of case. He doesn't care who gets mad at him." That was why I got more of these cases than I ever really cared to have.

The unavailability of medical testimony forces attorneys to go outside of the state to get experts who are legitimately subject to criticism as being professional witnesses. This problem comes because though physicians within this state will talk to you confidentially about what has been negligently done, they

are not available to testify, because of the criticism and ostracism of their colleagues when they do.

Another interest group is the public. There are two aspects of their concern. One aspect is that everyone has to see and pay for doctors and so they are concerned with the cost of medical insurance. The other aspect is that everyone is potentially a victim of a doctor's negligent act. Their rights also had to be considered.

These statistics were presented to the Governor's Committee covering the 5 years before it met in 1975. They showed that the five leading, and I believe practically exclusive, writers of medical malpractice insurance coverage earned premiums of over \$7,365,000 and incurred losses of \$4,509,016. The figures showed that only about 57 percent of the earned premiums were ever paid out or reserved for payment against claims that had been made, which is a pretty good loss ratio in any business. This didn't make any difference. These carriers were still refusing to write policies, or else they were tripling premiums or pulling out of business altogether because of experience in other states.

In essence, then, what did the legislature do. They passed an act that had two principal elements. The first element deals with the unavailability of insurance. It provides a procedure known as a joint underwriting association. Through it the Commissioner of Insurance can, if he determines that a crisis exists in the availability of malpractice insurance coverage, cause all the various insurance underwriters in the state who deal in the liability field and in the hospital and physicians' medical payments field to form a pool. This is reserve legislation. The commissioner reserves the power to impose this underwriting responsibility on this joint underwriting association when he determines that a substantial number of doctors in the state may not be covered by malpractice insurance.

The other major aspect of the law that was passed is the patients' compensation fund. It operates in this fashion. Every doctor and hospital is required to insure against his own personal liability in a certain basic amount. It applies to doctors and hospitals on a mandatory basis and to other health care providers on a voluntary basis if and when the Commissioner of Insurance should order it. It says that physicians and hospitals have to provide a basic insurance coverage for themselves of \$100,000 per occurrence, \$300,000 per year. It says that they no longer have to buy the umbrella policies. These were, we were advised, the real problem in causing the enormous expense and unavailability of insurance, particularly to the physicians in surgery and anesthesiology. Under this plan, every physician and hospital will be assessed an amount equal to 10 percent of his premium on basic insurance, which will be paid into a fund known as the patients' compensation fund. It will accumulate and will be available to pay the excess of any judgment of over \$100,000 against a physician or hospital. Those judgments in Kentucky have been few and far between.

I was a great believer in having this fund, but I did not want it to operate in the manner in which it did. Why collect money from physicians before a loss

actually occurs? One may never occur. I suggested that the act should be written in a manner whereby if a lawsuit was won and a loss becomes payable, it would be paid out of the general fund of the state, and would then be recouped in the next year. For instance, if there was a million dollars that had to be paid out of the fund for 1975, then on the 1976 income tax, every physician would have an assessment against his gross income which would be under one percent--whatever is necessary to pay the state so that the money paid by the state would then be recouped. If nothing had been paid out, then no assessment would be made. I could well envision that for many years there would be no need for physicians to pay anything into the fund.

The physicians on the committee, the hospital administrators, and various representatives of the physicians' aides, however, preferred the advance payment of a percentage of basic policy premiums. Since it was out of their pockets, certainly they were entitled to have the fund constituted in a manner that they preferred.

There are other features in the plan which are of consequence. The first has to do with the ad damnum clause in a complaint. This is the demand clause in the complaint, which states how much you are sued for. For a long time, this has been a real bone of contention for people who are regularly sued for one reason or another. The suit is filed for box car figures, and that gets a lot of publicity. Then later on, if the suit had no merit, it is dropped or settled for an amount much smaller than the box car figure sued for. The act simply provides that the demand clause in the complaint shall not recite any alleged damages sum and that it will just ask for such fair and reasonable compensation as the trier of fact should determine is appropriate. You will not be faced with that box car figure. The insurance carrier defending you can assess the potential value of the claim, and set up their reserve accordingly.

They are obligated by this act, when they think that the claim has a potential in excess of \$100,000, to notify the patients' compensation fund so that the fund can deal with its potential liability. A good side aspect to the program passed by the legislature is that because of the potential liability of the fund, there has to be reporting of claims to a central agency and some kind of investigation where the type or the amount of claims is such as to indicate that we have a physician that is really incapable of practicing medicine up to the standard that the medical profession has a right to expect.

"Medical malpractice" is a misnomer which I wish we could get away from. In essence, 99.9 percent of the time, all you are talking about when you use the term medical malpractice is negligence, pure and simple. You'll find pronouncement after pronouncement by our Supreme Court specifying that we're not talking about a mistake in judgment which is a reasonable decision in the circumstances. We're only talking about those situations where there's been a failure to exercise ordinary care and someone is injured as a result of that negligent act or omission. That's the only time when compensation should be available. I make that point

because that brings me to another point in the Act.

The Act provides for an objective standard for a claim against a physician in cases concerning informed consent. Some physicians have overreacted to the potential claim for failure to provide informed consent. The truth of the matter is that the cases where there's been compensation awarded on that basis are very, very few in Kentucky. To alleviate any fears that doctors might have in this respect, this Act provides an objective standard. Informed consent doesn't just relate to what the patient or his lawyer might think should have been told to the patient, but what a reasonable physician should be expected to tell a patient in the circumstances.

Our Court of Appeals has already decided upon this standard in a very recent case which specifies that informed consent will be treated just like every other negligence problem--reasonable conduct in the circumstances. As with other types of malpractice, the plaintiff will have to prove by experts that there was a failure to follow standard medical practice in the advice to the patient, unless, of course, you have a situation so flagrant that the facts speak for themselves. You don't have to worry about subjective standards for informed consent anymore. That's a problem that's gone.

The next problem dealt with by the statutes is the problem of secrecy, privileged communication, and confidentiality. Specifically, the problem is whether evidence developed in peer review procedures showing negligence on the part of the physician should be discoverable as are all other types of evidence. The Act as passed provides a privilege against discovery for this evidence. It states that the proceedings, records, opinions, conclusions, and recommendations of any physicians' committee, or similar entity, shall not be subject to discovery, subpoena, or introduction into evidence in any civil trial. This, in effect, overturns a decision by the Kentucky Court of Appeals in Nazareth Literary and Benevolent Institution v. Stevenson, 503 S.W.2d, 77 (Ky. 1973), wherein the Court ruled against privileges.

The committee and the legislature did something in passing this Act contrary to my suggestion. I suggested that they make participation in the patients' compensation fund in this act voluntary. However they wrote the Act, saying you "shall" join the patients' compensation fund. A suit was filed in the United States District Court--it's Floyd v. Carroll--for declaratory relief. This suit attacks two elements of the Act. The first element is the constitutionality of that part of the Act that states that doctors must belong to this fund in order to practice medicine and which provides that if they are reported to the state licensure board for failure to belong to the fund, it will be grounds for suspending their license. The plaintiffs argue that the practice of medicine in which they are engaged is a means of livelihood and thereby is property within the meaning of the 14th amendment to the Constitution of the United States. They argue that the part of the Act that says that if they don't or can't get into the fund, they can't practice medicine, deprives them of their right to practice medicine without

due process of law. They may well have something, because the Supreme Court of the United States has ruled that an act which took away a man's license to drive without prior evidence that he was guilty of any negligence in the way he operated his car or other misconduct, was unconstitutional. I would think that a license to practice medicine should have at least the stature of a license to drive an automobile.

Very surprisingly to me, the doctor plaintiffs also attacked, in this suit, that part of the Act relating to the confidentiality and immunity of such proceedings, records, opinions, conclusions, and recommendations of peer review boards, as wholly incompatible with and contravening a section of the Social Security Act wherein the professional standards review organizations were created by the Congress of the United States. The suit claims that the Act should be declared void because this is violative of the supremacy clause of article VI of the Constitution of the United States. The supremacy clause, of course, provides that the state cannot pass any law that interferes with the function of the federal law. The message is: Don't cancel your umbrella policy. Although the Act specifies that it is effective July 1, the Act is not necessarily constitutional, and you may very well need that umbrella policy if it isn't. I understand also that there is a state action that's been filed that also attacks the constitutionality of the Act as passed.

#### QUESTIONS AND ANSWERS

QUESTION: Judge Leibson, can you answer whether the Indiana law is being attacked constitutionally?

JUDGE LEIBSON: There is a malpractice suit that has been filed in Indianapolis by a lawyer named Townsend. I don't remember the name of the suit. That will raise the constitutionality of the Indiana law which will have to be thrown out because it doesn't go through the screening panel procedures provided in the Indiana Act. Also, it doesn't restrict itself to the limitations on amounts that are provided. Those screening panel procedures that I'm talking about are procedures that say that before the suit can be filed it has to go by mandatory provision to the three-man committee of physicians to render an opinion on the matter.

QUESTION: Judge Leibson, if a physician is being questioned or reviewed by the professional standards review organization, will he be able to obtain standards which are applied to other medical areas in Kentucky, and will the act that you spoke of affect the confidentiality of those records?

JUDGE LEIBSON: The act will positively affect the confidentiality of those records. If you are approached to write an opinion about a fellow physician or to give testimony yourself in any peer review procedure, the information or evidence you provide will be confidential under this Act. As to the other part, we in Kentucky no longer recognize a locality rule. We say that everyone who is a board certified orthopedic surgeon should adhere to the basic standards of that profession. Locality doesn't come into consideration, except if there aren't facilities avail-

able that he could use to practice his profession. But from a standpoint of knowledge, a board certified orthopedic surgeon, regardless of where he practices, is supposed to have the knowledge of a board certified orthopedic surgeon.

QUESTION: That pleases me. I represent the physician. My point is that I want to be able to discover the standards applied, I think arbitrarily, by this organization throughout other medical districts in Kentucky. I'm curious to know whether the Act will restrict me from even getting those standards.

JUDGE LEIBSON: I think the Act will restrict you from getting any information that is provided before that peer review board; at least I can tell you positively that this is the intention of the Act.

QUESTION: If the patients' compensation fund should become exhausted, would there be further assessment?

JUDGE LEIBSON: No. As I read it, all that it means is that any unpaid portion of the claims simply goes over into the next year and the claimant waits until the procedures of assessment have replenished the fund before he gets paid. It is a socialization, you understand, in the sense that a physician or a hospital no longer has a personal liability for his negligence over and above the sum of \$100,000. It's paid by an assessment against everyone in the entire profession. As opposed as I am, being a rugged individualist, to any form of socialization, I have to say as a practical matter that anything that relieves the medical profession from carrying the burden of paying huge premiums for umbrella policies that they never use, has to be a progressive step of which I approve.

## ARBITRATION AND OTHER ALTERNATIVES

John A. Krichbaum, J.D.  
Assistant Director Legislative Department  
American Medical Association  
Chicago, Illinois

Before I start the presentation of my portion of this program, I would like to comment briefly on something that the judge mentioned toward the end of his presentation, mandatory pretrial screening laws. To date, there have been only two state court decisions on this matter. A recent Illinois decision struck down the mandatory pretrial screening law (as well as striking down the limitation on liability). The Florida Supreme Court, however, has recently upheld the mandatory pretrial screening panel statute in that state.

I'd like to talk with you this morning about two subjects. The use of arbitration in medical malpractice cases, and the possible use of a no-fault system for medical malpractice. First of all I'd like to examine the constitutionality of arbitration as a substitute for the traditional judicial system for resolution of medical malpractice cases. Secondly, I'd like to discuss some of the potential advantages and disadvantages of arbitration as contrasted to the jury system for medical malpractice cases. Finally, I'd like to discuss very briefly what some of the states are doing by way of legislation in regard to arbitration of medical malpractice cases.

We might start off with a very simple definition of arbitration. Arbitration is a procedure whereby parties with a dispute submit their disagreements to an impartial third party, other than the traditional judicial system, for resolution.

It might be useful to keep two questions and two possible answers in mind during this discussion. First of all, is arbitration, as a substitute for the jury system, constitutionally and legally valid? My answer is sometimes yes and sometimes no. The second question to keep in mind is whether arbitration, as a substitute for the jury system is desirable. The answer, again, is maybe yes and maybe no.

First let us consider the constitutionality and legal validity of arbitration as a substitute for the jury system. In this examination I'd like to make it clear that I will not be talking about nonbinding arbitration, since whether it is entered into on a compulsory or a voluntary basis, if it is nonbinding, that is if either party has the right to a trial de novo following arbitration, then I believe it's more appropriate to call that sort of mechanism a pretrial screening. By binding arbitration, I mean that following arbitration there would be only a limited right of judicial appeal. There would be no right to a new jury trial, but only the right of appeal to the court on questions of law or on an allegation that the arbitration decision was against the manifest weight of the evidence.

Let's look at compulsory binding arbitration. Under this kind of arbitration, one or both parties are forced to enter into arbitration for resolution of any disputes. This compulsion could be either by operation of a statute or by

action of one of the parties. Is compulsory binding arbitration constitutionally or legally prohibited or restrained? My answer would be that compulsory arbitration, in the sense of a statute mandating that malpractice cases be submitted to binding arbitration, is constitutionally prohibited, and that compulsory arbitration, in the sense of a health care provider conditioning the rendition of services upon execution of a binding arbitration agreement, is legally restricted but not necessarily legally prohibited.

Why would a statute that required submission of medical malpractice cases to binding arbitration be unconstitutional? I believe it would be because of the constitutional right to a trial by jury in civil cases. Let me make it clear that I'm not referring here to this right as stated in the federal constitution. The federal constitution does not impose upon the state an obligation to afford trial by jury in civil cases. The provision in article III of the U.S. Constitution stating that "The trial of all crimes, except in cases of impeachment, shall be by jury..." and the seventh amendment, which states "In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved..." relate to trial in federal court only. The seventh amendment to the U.S. Constitution has not been extended to apply to the states.

There are a couple of citations on this. One is quite an old case, Walker v. Sauvinet, 92 U.S. 90 (1876). The Supreme Court held there that trial by jury was not considered essential to due process. Since the fourteenth amendment guarantees no particular form or method of procedure, states are free within the boundaries of their own constitutions to retain or abolish juries in civil cases. This position was reaffirmed in Williams v. Florida, 399 U.S. 78 (1970). Consequently then, the right to trial by jury in civil cases in state courts is not derived from the U.S. Constitution. However, the constitutions of every state have a provision guaranteeing the right of trial by jury in civil cases. Indeed, such a clause was in many state constitutions prior to the adoption of the federal constitution. Thus, we reach the conclusion that a statute, either federal or state which would make it compulsory that medical malpractice cases be submitted to binding arbitration, would be constitutionally prohibited.

What about compulsory binding arbitration in the sense of a health care provider conditioning the rendition of services upon execution of a binding arbitration agreement? I said before that I thought such a situation was probably legally restricted but not necessarily legally prohibited. What I mean is that the more the circumstances surrounding the agreement to submit to binding arbitration between the health care provider and the patient reflects a compulsory term of the agreement on the part of the health care provider, the more likely such agreement is to be struck down by the courts as being invalid because of undue influence or duress. On the other hand, the more the circumstances surrounding such an agreement reflect a voluntary agreement to submit to binding arbitration, the more likely such an agreement is to be upheld. That's pretty general, but there are principles that you have to keep in mind if you are drafting either legislation or private



arbitration agreements between health care providers and their patients.

A voluntary agreement to submit to binding arbitration indicates a waiver of the right to trial by jury and is valid in most states. In eight states within the past year and a half--Alabama, California, Louisiana, Michigan, Ohio, South Dakota, Vermont, and Virginia--such voluntary binding arbitration agreements and their implementations will have to be in accordance with specific statutes enacted in these states relating to binding arbitration in medical malpractice cases.

In some of the other states such voluntary binding arbitration agreements will probably be legally valid if executed and implemented in accordance with the general statutory arbitration guidelines of the state. There are about 33 states which have enacted a general arbitration statute. In other states such voluntary binding arbitration agreements might not be upheld because of case or statutory law in the state which might say, for example, that the application of the law is a judicial function which cannot be done in a binding way by nonjudicial personnel. Case law in some states might make it very difficult, as a practical matter, to have voluntary binding arbitration agreements construed as actually being voluntary.

I would like to mention several of the factors which support voluntary binding arbitration agreements being construed as actually being voluntary. Some of these factors are required in the specific medical malpractice statutes which I referred to as having been enacted within the last year and a half in eight states. Foremost among these might be the right of the patient to reject the binding arbitration agreement within a designated number of days following provision of the services or signing of the agreement. This provision is in all but one of the statutes that were enacted in the eight states I mentioned. Two of the eight statutes apply only to past disputes. You can in those states agree to arbitrate only disputes which have arisen. In the other six states you can agree to arbitrate future disputes. In five of those six states a provision exists in the law which requires that the law contain a provision for the patient to reject the arbitration agreement within a certain number of days following the provision of the services. This is put in to uphold the voluntary nature of the agreement. If a patient is coming in for provision of necessary services, he may be quite willing to sign anything to obtain those services, but a court looking at that type of situation in retrospect might very well conclude that the agreement was really not a voluntary undertaking on the part of the patient. The solution, may be to draw the agreement so as to allow the patient to reject the arbitration agreement within so many days following either the entry of the arbitration agreement or the provision of services. The argument, frankly, doesn't hold up quite as much if the days are numbered from the entry into the agreement as it does if the days are numbered from the date of provision of the services.

A second factor which helps uphold the voluntary nature of the arbitration agreement is when the circumstances surrounding the execution of the agreement as well as the language in the agreement make it clear to the patient that the provision of services is in fact not dependent upon execution of the agreement. It

should be noted at this point, however, that whether a condition for rendering services is the execution of a binding arbitration agreement will obviously have different legal consequences depending on the setting and the parties who are executing the agreement. For example, if the condition is part of a prepaid group practice plan which the patient enters prior to any immediate need for services, it is quite likely that the agreement will be upheld. See Doyle v. Guilucci, 401 P.2d 1, 43 Cal. Rptr. 697 (1965). Likewise, it would seem likely that an agreement to submit to binding arbitration which was entered into between a physician and a patient prior to any immediate need for medical care would be upheld in most states.

Both of the situations mentioned above would be considerably different than a situation in which a hospital made entering the hospital conditional upon execution of a binding arbitration agreement. In such a setting the agreement would probably be struck down by the court. Another California case which you might want to have on this is Tunkl v. Regents of the University of California, 60 Cal.2d 92, 383 P.2d 441, 32 Cal. Rptr. 33 (1963). A very well written law review article on this subject is by Fredrich Kessler, entitled "Contracts of Adhesion--Some Thoughts About Freedom of Contract," 43 Columbia Law Review (1943).

What are the potential advantages and disadvantages of voluntary binding arbitration as a substitute for the jury system in medical malpractice cases? I'll list some of the potential advantages first. It's a speedier method of handling claims. Proponents of arbitration say that because of the informal nature of arbitration proceedings, claims can be handled in less time than in the traditional litigation system. The second potential advantage is that it provides a higher degree of sophistication in the decision making process. Proponents of arbitration say that it permits the use of experienced and knowledgeable decision makers such as physicians and lawyers, which will result in more informed and appropriate decisions. A third potential advantage is that it provides less emotional or irrational decisions. Proponents say that a panel of arbitrators is much less likely to be swayed by irrational and emotional appeals than is a jury. A fourth potential advantage is less publicity. Since arbitration is a contractual remedy, it provides a benefit, proponents say, of having disputes remain in a private setting. The sensational aspects of a jury trial are thereby avoided. A fifth potential advantage that's mentioned for arbitration over a jury system is that it is a mechanism which provides for less judicial appeal. Arbitration awards are more final than jury awards, since reasons for judicial appeal are fewer in arbitration, and proponents say that this will lessen the number of unnecessary appeals.

Now I'd like to mention a few of the potential disadvantages of arbitration. One would be the loss of the procedural safeguards which judicial litigation provides. The informality of arbitration proceedings is a two-edged sword. The informality may speed up proceedings, but it does, of course, sacrifice traditional procedural and evidentiary safeguards. Under most of the enacted medical malpractice binding arbitration statutes, the formal rules of evidence do not apply. The absence of

evidentiary objections probably harms the defendant more than the plaintiff.

A second potential disadvantage of arbitration is the loss of jury sympathy for the defendant. A number of physicians will find this hard to believe, but traditionally juries have been quite reluctant to find against the defendant physician. In fact, national statistics show that, depending on the state, from 66 2/3 to somewhat slightly over 80 percent of jury decisions in medical malpractice cases are decided in favor of the physician-defendant.

Another potential disadvantage is that publicity concerning the effect of large malpractice awards on rising health insurance premiums may cause some jurors to reconsider awarding inappropriately large sums of money. There is some evidence that this is taking place, for example, in California. It is also possible that the more sophisticated panel members who might have a better understanding of the loss of income may actually place a larger value on it.

A third potential disadvantage of arbitration is the easy availability of arbitration. This factor may encourage some frivolous or nuisance suits.

A fourth potential disadvantage is that arbitration may more often result in compromise dispositions rather than in a clear finding of liability or fault. Arbitrators, it is often said, feel that they are doing a good job if they come down equally on each side of the coin over a period of time. Therefore, there might be some tendency for arbitrators to try to encourage settlements rather than to reach a clear resolution of the issues.

A fifth potential disadvantage is that the nonpublic nature of arbitration proceedings may make them appear suspect to the public. Some critics of arbitration say that it may avoid the healthy pressure of "law suit publicity" as a device for encouraging quality health care.

A sixth potential disadvantage of arbitration is that as a mechanism for limiting the right of appeal, it may make it considerably more difficult to correct erroneous or unjust decisions.

The problem with making a decision for or against arbitration, even after having heard some of the potential advantages and disadvantages, is that there hasn't been a lot of experience with arbitration of medical malpractice yet. There have been, of course, some voluntary arbitration programs that have been in operation for a number of years, but there has been no widespread experience with the use of arbitration for medical malpractice cases.

I'd like to make a few remarks about some of the specific medical malpractice voluntary binding arbitration statutes which have been enacted in some states. As I mentioned before, all of these statutes were enacted within the past year and a half. A few of the specifics in some of these malpractice arbitration statutes might be of interest to you. I mentioned that statutes in two states provide only for what might be called post-claim arbitration. That is, the statutes provide that it is only after a physician or other health care provider has rendered or failed to render services out of which a claim has arisen that the parties may agree to settle such disputes by arbitration. The two states are Vermont and

Alabama. The California law, which permits agreements to cover arbitration of future disputes, requires that the arbitration agreement contain the following language immediately before the signature line in at least 10 point bold red type:

"Note: By Signing This Contract You Are Agreeing To Have Any Issue Of Medical Malpractice Decided By Neutral Arbitration And You Are Giving Up Your Right To A Jury Or Court Trial. . ."

All of the specific medical malpractice binding arbitration statutes except one (South Dakota), which permit arbitration agreements to cover future medical malpractice agreements, provide for a certain period of time, either following execution of the contract or provision of the services, in which the patient may reject the arbitration agreement. I think this fact highlights the importance of such a provision.

Now, I would like to make a few brief remarks regarding a no-fault approach to medical malpractice. I think there are severe constitutional questions about a no-fault system for medical malpractice cases. The issue of whether state legislatures can modify or substitute or do away with rights that existed in common law is one problem area. In any number of state constitutions there are provisions that rights that existed at common law shall not be changed or modified. Of course, someone might ask about workmen's compensation statutes which modified rights at common law. The legal decisions all the way from the U.S. Supreme Court down to the state supreme courts, relative to workmen's compensation have indicated that if there is sufficient quid pro quo, if something sufficient is given back for that which was taken away, then the legislature can constitutionally modify or change rights which existed at common law. Therefore, while it may be theoretically possible to structure a no-fault medical malpractice system which would be upheld constitutionally, it would be subject to quite a bit of argument about whether there was in fact a sufficient quid pro quo, a sufficient trade off.

For example, the New York panel which recently studied no-fault came up with suggestions for a no-fault system. Their suggestions are all very general. They are very fuzzy about the question of how you define a compensable medical injury. They cite the recent judicial decision in New York upholding the New York automobile no-fault statute, but even in their study they note that that statute provides for no-fault only up to a point. In other words, you can get a certain amount of money under the statute, but beyond that you may sue in court for "serious injuries."

Beyond that, the desirability and workability of a "no-fault" medical malpractice program would be subject to serious question. Should physicians, for example, support with their premiums a system which is going to provide compensation even where the physician is not negligent? Would this greatly expand the number of incidents for which doctors are going to pay? I think that it would.

How do you come up with a definition of what is going to be compensable and what's not? Is it going to be easy to say that the person's condition is the result of a medical accident rather than the injury or the disease for which the

the patient initially sought treatment? I think that this would be extremely difficult. One of the approaches being suggested is to try to come up with a specific list of all the compensable types of incidents. I don't think that would be very workable.

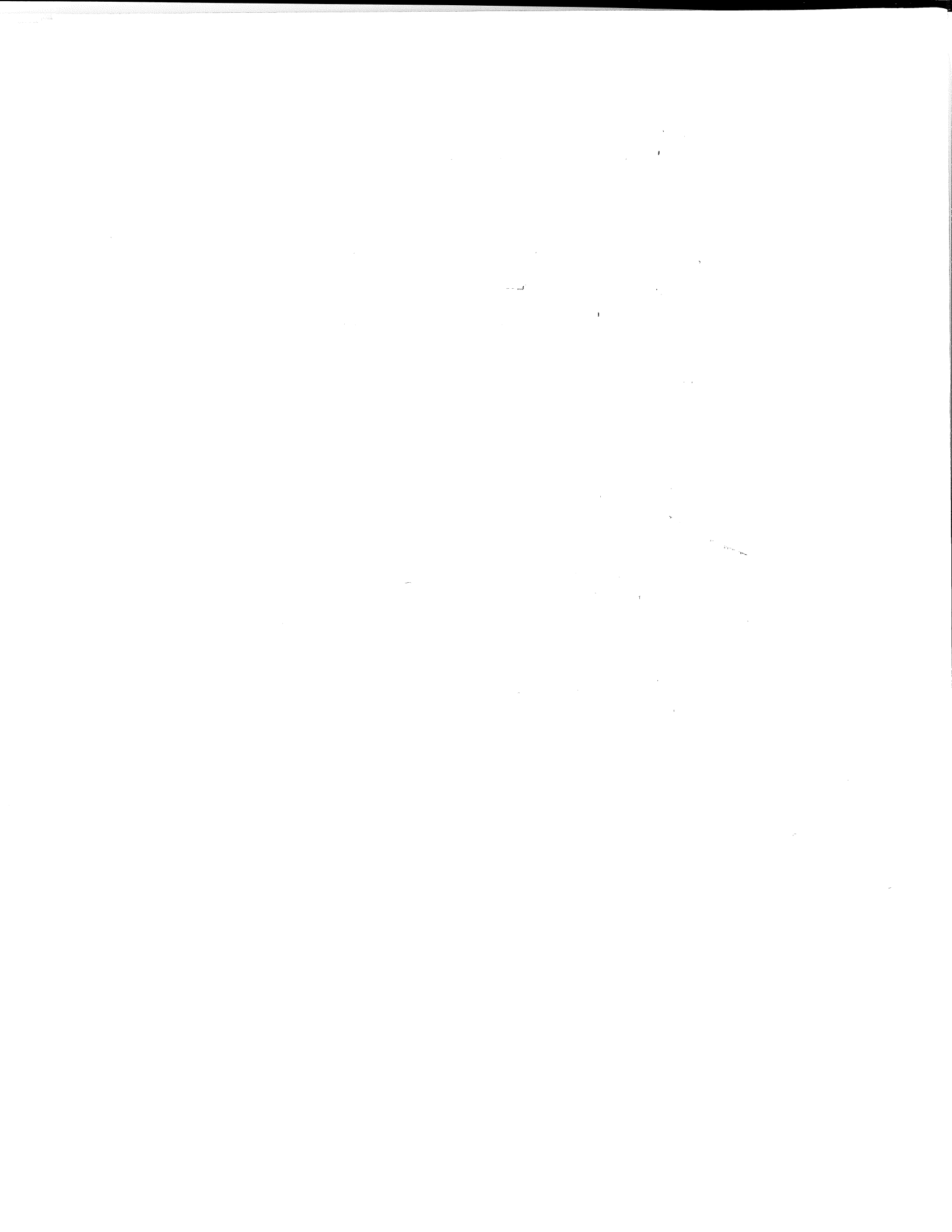
QUESTIONS AND ANSWERS:

QUESTION: I have two very brief questions. First of all, you were talking about factors relating to the voluntariness of the agreement and the right of the patient to reject it within a certain amount of days. Are there any provisions in the statute that deal with the question of what happens if the patient dies or becomes mentally incapacitated? Would the patient's personal representative have a right to reject the agreement?

MR. KRICHBAUM: Most of the statutes provide that it can either be the patient or his authorized representative.

QUESTION: My second question deals with the potential advantages of the more sophisticated decision making process with attorneys and physicians on the panel. Is there any provision for any sort of consumer input which would perhaps counter-balance what might be an over-professionalism in hearing such a case?

MR. KRICHBAUM: I think that's a good question. I know that most of the medical malpractice arbitration statutes indicate that there will be an attorney, a physician, and a judge. Several do provide for consumer or lay representation.



## RISK CONTROL

Paul A. Van Pernis, M.D.  
American Medical Association  
Chicago, Illinois

In discussing professional liability, we are forced to talk about malpractice; I don't really know how we can separate the two terms. The word malpractice means "bad" practice, and what we have to try to do is minimize the instances in which bad practices occur. Although not all professional liability action stems from malpractice, where it's truly bad practice, there is insufficient attention to risk control.

Considerable effort to minimize the sources of risk have been made by various hospital associations and some of the insurance carriers who write policies for institutions. Some efforts at education in this area have been made by "medical specialty" organizations whose membership is primarily based in institutions. Most notable are the educational efforts of the College of American Pathologists. Although many other professional associations have begun similar efforts, little has been done by most state or county medical societies. State and local building codes, fire department regulations, and some national bureau regulations and advisory statements have been promulgated, but follow-up and enforcement is sporadic and all too often a catastrophe of some sort follows. My purpose is to attempt to point out the sources of the individual physician's risk with the hope that more awareness of the problems will occur, that something will be done about it on a personal basis, and that each one of you will involve his colleagues in clearing up the problems.

The physician faces risk in the office environment, hospital environment, and the community or other agencies in which he or she works. I shall now ask a series of questions concerning some of the sources of risk, hoping that you may be stimulated to think of some others for yourself, hoping that you'll make comments, and most of all hoping that you will resolve to do something about the uneasiness such questions may engender.

The physician's office:-- let's start with the patient's waiting room and the building in which the doctor practices. Does the building and its environment make it easy and safe for patients to come to see you, particularly if they have physical disabilities? Is your office's patient waiting area quiet and reflective of a professional atmosphere? Have you oriented your office help to your procedures? Do you set a pattern of concern for patients that the office personnel can follow? Is the wiring safe for lamps between furniture? Are the floors safe? Can patients move into and out of chairs without assistance? Are there accommodations for the elderly and the physically disabled? Are there provisions to prevent waiting patients from overhearing conversations between office personnel and telephone conversations? Is there privacy between office personnel and patients who are discussing finances, consultation arrangements and hospitalization or other institutional arrangements? Is there another exit for treated or

acutely ill patients other than the main entrance to your office? Are office patient's records kept in confidence from other patients or other persons not part of your office personnel? These are the things that have brought suits; these are things we have to think about.

What about the examining and treatment room? Is privacy insured? Do you have a nurse present when you examine patients of the opposite sex? Could the patient or physician or nurse quickly summon help when necessary? Is the lighting adequate? Is sufficient help available to assist both the patient and yourself? Are the examining tables and chairs safe? Are the instruments, appliances, and other equipment periodically checked for safety, reliability, and accuracy? How often are they checked and by what standard? Who checks them? Do office personnel understand the maintenance and purposes of the equipment and the checking against known standards? Who instructs them? Do you or your personnel explain to patients why you wish to use the equipment? Do you explain its possible hazards as well as its benefits?

Now let's examine the patient. Is your record of the patient's medical history a thorough and complete one? How was it obtained--by you, by your office personnel, or by electronic recorders? Did you verify what your personnel or the black box recorded? Did you add, delete or correct the record? Did you date and sign it? Did you make certain of its confidentiality? Did you do a thorough and complete examination and record the findings in detail, whether positive or negative? Did you request the necessary laboratory, X-ray, electrocardiographic or other studies? Can you justify the expense of doing them? Did you personally obtain the necessary specimens or supervise the obtaining of such specimens? Who does the procedures? Do you know that those doing them are reliable, accurate, prompt, and have accepted standards against which the results are checked?

Have you visited the laboratories personally so that you know the personnel, their qualifications, their participation in outside quality control checks, the result of such outside checks whether voluntary or legally required, with or without licensure? Did you examine the data obtained, transfer it to the patient's records, date and sign such data and make the necessary interpretations or request a repeat of the procedure or procedures? If you did not record the results, do you have a system that alerts you to abnormal findings so that appropriate treatment can be instituted, or medications and dosages changed? Did you relate temperature changes of specimens, shipping time, and time of obtaining specimens, or medications or dietary factors which might interfere with the data in its interpretation? When necessary, did you explain to the patient why another specimen is needed and at whose expense the procedure is to be repeated?

Do you know the individuals in the radiology laboratory? Do you know the individuals in the occupational therapy department? Do you know the people who are going to do other tests like an electroencephalograph, for instance? Do you know the people who are directing the activities of these people? Did you allow sufficient time to obtain the patient's medical history? Do you obtain the



necessary consultations, discuss the diagnostic and treatment plans with the patient as well as with the family, your office personnel, the hospital or other institutional personnel as indicated? Did you discuss the hazards and the prognosis? Did you indicate this on your patient's record and inform the patient that such a record was made?

Did you obtain the necessary signed consents from the patient or the family, including a statement that the patient agrees that he was informed, and that he understood your plans, diagnosis and prognosis? Did you inform the patient about the relationship of residents and other students to the patient and what their role would be in the situation, provided you're in a teaching situation? Did you have a witness to such discussions? Did you note on the record who the witnesses were? Did you give the patient written directions concerning the treatment plan, medication, consultations, hospitalization, etc? Did you confer with other physicians, therapists, technicians, pharmacists, and social agencies--in person or in writing--and did you inform the patient or family member about these conferences? Did you ask any of these persons to confirm appointments directly with the patient or with a family member? Did you consider how the patient would get home, to another office, or to the hospital, etc. and make arrangements for transportation when necessary?

Did you arrange for future appointments and verify such arrangements in writing for the patient or his family? Were all the surgical procedures or other therapy performed in a proper setting with proper techniques and proper assistance? Were dressings, casts, applications, or other treatments done by you or under your direct supervision, and did you recheck such applications within proper intervals? Did you record on the patient's record what was done? If you took photographs, did you attach them? Did you date and sign the record and record witnesses when necessary? Do you have a mechanism to handle complaints about your fees? Do you discuss fees in advance with patients? If patients believe they are overcharged, do you let your office manager handle the complaint? Does your office staff help patients fill out claim forms? Do you refuse to provide information that patients need in order to submit claim forms--for instance, workmen's compensation, or personal injury claims--unless you have been paid for the service? If a patient needs to have his or her records forwarded to another physician or another institution, do you resist by making the transfer of information contingent on the payment of his or her account? Do you allow enough time for appointments, and to listen to the patient's concerns?

What about the physician himself? Have you put aside or resolved personal frustrations that might interfere with the care of patients? Are you certain that personal illness will not affect your care of the patient? Have you provided sufficient time to provide high quality patient care for both office and hospitalized patients? Have you arranged for adequate explanation to your office personnel and to patients when unforeseen interruptions occur? Have you provided time for continuing education, the reading of journals, and drug experience information for your-

self and your office force? Have you provided time for participation in peer review activities? Have you provided time for reflective review of patient's records, your consultations, and did you initiate any necessary corrections? How much do you rely on detail men for your knowledge of drugs and their use? What about your relationship with the hospital or other institutions? Do you really know and understand the medical staff rules and administrative rules of the institution in which you practice? Do you understand the use of mechanisms provided to make changes you believe need to be made? Are you prepared to explain the use of consultants, assistants, and ancillary services to your patients? Are you certain that your discussions with and about patients are kept confidential and not broadcast by corridor or public area discussion? Are you courteous but firm when discussing errors with hospital personnel, and do you inform your patient as to the corrections being made? Are your own personnel instructed about hospital routine and procedures when they assist or accompany you to your hospital? Have you made certain that the hospital records on your patients are complete, accurate, and detailed? Did you check the accuracy of notations made by others of the health care team? Did you write a summary of the case? Did you discuss with your patient the hospital charges and fees when the patient is in the hospital?

What about the insurance relationship and the follow-up you expect to give upon discharge from the hospital? Did you put the necessary directions to the patient in writing and inform a member of the family or the guardian as to your plan? Are you certain you were understood? Are you available for further questions?

The questions I have raised relate to what we know as traditional medical care of patients with manifest disease. Other questions will arise with the implications of modern comprehensive health care since health is now a basic right. I would suggest that you consider similar questions as related to health education of patients, health protection of patients, health maintenance for patients, diagnosis and care of symptomatic disease, care of the dying, and rehabilitation and custodial care, which are all now considered to comprise the range of medical services the public needs.

I don't want to leave you with a feeling that I know all the questions and answers. What I've said is really common sense. It's application of the golden rule. I'd like to leave you with this question: suppose you were the patient?

A PLAINTIFF'S LAWYER VIEWS MALPRACTICE

William C. Ball, J.D.  
Ball and Nagel, P.C.  
Waterloo, Iowa

I assume that anyone attending this conference has reached the point in his reasoning where he recognizes there is such a thing as malpractice. I run into some physicians who will not recognize this, but I'm not going to spend a great deal of time on that problem. Instead I'll try to define it and to talk about the three people that are involved in malpractice. First, we're talking, normally, about a patient who's been injured. By an injury I mean some inordinate or untold result from medical treatment which may or may not have been caused by the negligence of the doctor. Second we're talking about a lawyer to whom the injured patient goes. And of course we're also talking about the physician. I'd also include the care facilities, such as the hospital where that patient was treated.

When injured patients come to me, it's my duty to sort them out. Where do they come from? Basically, they come from referrals from other lawyers around the state of Iowa. On a few isolated occasions they come from outside the state. There are usually two reasons they are referred. The first, in most instances, the referring lawyer tells me, is because "It's against a local doctor, and I can't handle the case. I need his future cooperation." This implies to me a certain unrealistic relationship between the professions. The second is more justifiable. He'll call me and say, "Hey, Bill, I wouldn't know one if I saw one. Will you please look this thing over and tell me what's there, if anything, and I'll be happy to work with you on any basis that you want me to, or if you don't, fine."

The main characteristic of the people that are sent to me in most instances is that they are in the dark. They have not been given an adequate explanation as to the reason for their bad result. Obviously, our hornbooks say that a bad result does not necessarily mean negligence, but there's usually been a breakdown in communication between the physician and the patient. In many instances this breakdown is totally unjustified because upon investigation of the case, after consultation with a physician who's knowledgeable in the area in which the injury occurred, we will often write the patient a letter--which quite frankly should have been written by the attending physician--explaining to him the reason for the result that was obtained. In some 25 percent of the cases, the patient is angry because there's been a complete breakdown of communications between him and the physician. In many instances, of course, this is a sign that the physician is rather sensitive about the result obtained, whether justifiably or not. Perhaps he's trying to hide something. This is a hallmark. It's not a controlling factor, but it is something that does happen.

In some cases there is genuine medical injury which you don't need to be a doctor or lawyer to figure out shouldn't have happened as when the clamp

slipped off inside the patient. These fall into that terrible doctrine of res ipsa loquitur. The patient comes in and wants to know what to do. I had one of those, and I told the lady to see a surgeon and get it removed because she was sitting in my office with it in her.

Finally, there is one thing that the patients recognize--as far as I'm concerned, the medical profession is in real trouble with the public in this particular area. This is the extreme reluctance, which I consider to still be in existence in this country, of physicians to testify in legitimate malpractice cases against another physician. I'd like to relate the observation of a lady who brought her son in because of an undiagnosed wrist fracture. She wanted us to look at the case for her. When I explained this problem to her, she looked at me, opened her eyes in surprise and said, "Did the doctors take an oath to protect one another?" This was her reaction. I told her no, they take a different kind of an oath. I think this is something the medical profession should talk about.

But let's talk about the lawyer for a minute because this is a many-faceted problem. The fault, in terms of the crisis in this area--and there is a crisis--is not only the fault of the medical profession. We can lay part of the problem on the lawyers. First of all, what do I tell someone who comes in to see me when they think they have a case, or when they want to know if they have a case? I tell them that we turn down at least 80 percent of the people who come in after we've investigated their cases. I was talking to a leading firm in the midwest, which keeps statistics on medical malpractice cases. Of the 100 cases that they screened in the last 2 or 3 year period, they took five. They turned down the other 95. Doctors complain about the contingent fee system, but the contingent fee system is the best thing the doctors have going in terms of the proper screening of medical malpractice cases. There are no fools taking lawsuits they can't possibly win on a contingent fee basis.

I tell the people that if we accept the employment, it will be on contingent fee basis, but that it is necessary and vital to the patient's interest, the doctor's interest, society as a whole, and the attorney's that the matter be thoroughly screened in order to determine as many facts as possible before filing the claim.

We obtain copies of all records. Many times I'll write doctors requesting the records, and I'll send them a patient's authorization, but I won't hear from them. Many times the answer to whether or not there is in fact negligence lies in the doctor's records. If he doesn't give them to me, what am I supposed to do? If the records contain a crucial point, I suppose we have to file the suit and subpoena them. So I would caution doctors at this stage that you should talk to your lawyer candidly about this. In certain instances you may want to furnish the records where in the past you may not have.

I indicate further to the client that it's necessary in this screening process for the attorney to research the proposed action thoroughly before accepting the case. I would emphasize this. The time to do your legal and medical research,

inasmuch as it's humanly possible, is prior to making a claim. Don't write doctors letters and tell them you are going to sue them when you don't know in fact whether there is a case or not. It detracts from the dignity of our profession, and as far as I'm concerned is harassment of the doctor. I'll go on the record as being critical of the legal profession when this happens.

I also tell potential clients during the screening process that I always talk to the physician, even in the obvious cases. Normally I will talk to board certified physicians who specialize in the area of the injury that was involved. Sometimes these are local physicians who have confidence that I handle these claims honestly, and reject the ones that are spurious or not worthy of further action. Sometimes they are physicians in distant places. At all times we attempt to obtain practicing physicians. The fact that a physician testifies in the medical malpractice case may mean that he feels that the patient is entitled to this testimony in order to balance our society.

I also tell potential clients that there is going to be a contingent fee basis if the case is accepted. There's hardly anyone in this society who can afford an attorney on any other basis in these cases. If the doctors are successful in their legislative efforts to abolish the contingent fee, they will to a large extent abolish medical malpractice suits as well. Obviously the doctor has a well-paid attorney who is hired by a multi-million dollar insurance company, and I quite frankly have to ask you whether it would be a fair fight. If the patient has serious injuries, he is incapacitated. He might be on social security or unemployment. How can he be told that he should hire someone at \$50, \$75, or \$100 an hour to prosecute a malpractice claim against a doctor? I submit that it's inherently unfair and that it violates our very concepts of justice in this country.

I also mention to the people that come in that the doctors win 75 percent of the cases tried in this country. It isn't necessarily because 75 percent of the cases are not meritorious. It's more because of the ability of the physician to marshal medical evidence on the crucial issues in the law suit--the medical issues. As you know, medical testimony in a medical malpractice case is practically a necessity. A plaintiff's lawyer who goes into a medical malpractice case without medical testimony should re-examine his case rather carefully.

I also tell the interviewees that in the event we accept the case there are going to be court costs and immense fees involved. This will run anywhere from \$1500 to \$20,000. If you want a genuine medical expert to travel to Waterloo, Iowa or Lexington, Kentucky, it's probably going to cost around \$1000 a day and travel expenses. These kinds of risks are necessary to enforce what amounts to a recognizable legal right in our country. When you talk about limiting the right of the patient's redress to the courts, I ask you, in terms of the concept of fair play in this country, whether this really makes sense.

I mention something else to these people--and I think this is something that doctors and lawyers should consider very carefully. There's little likli-

hood that the case will be settled prior to suit. I've had several cases recently where I literally pleaded with the insurance adjuster to settle the case. They were cases of obvious liability. One was a case where a duct was cut in a gall bladder operation. Not only did the doctor cut the duct, but he also failed to check to determine whether it was cut after he commenced his closure procedures. We had two different board certified surgeons say that there was negligence. I had another case where a man went in for a gall bladder operation and came out with a bad arm which, as you well know, was probably caused by positioning during the operation. In both cases the insurance company refused to settle the case. It had to be filed, and they then settled the case after discovery. It's kind of a sad commentary. It seems to me that the insurance industry's job is to protect their clients. That's their first duty and that's what the courts have said. When I see cases such as these that are not settled and I have to file them, I get sick because it's not necessary that these cases be filed at all. The surgeons that were involved were basically good doctors, but they made a mistake. They injured someone, but that's why they carry insurance.

I tell all my doctor friends--you may not believe it, but I have a few--that one of the first things they should do when they are served with notice of a malpractice case is to get their own lawyer. In this way, they will be adequately advised and the insurance company can recognize the fact that the doctor is independently represented. Quite frankly, if I have a case against me that I feel is an obvious case of negligence, I'm going to call my insurance company and tell them they'd better settle or I'm going to admit liability--as long as the settlement demand is within a reasonable area. In the one case I settled, my settlement demand was less before I filed the suit than it was when we ultimately settled the case. Again, I don't think this is proper; I think that the insurance industry needs to reexamine itself here.

Finally, the last thing I mention to these people is that it is an absolute necessity that we obtain medical testimony to support their position. I then indicate to them the extreme difficulty in obtaining this testimony. I think that if I had to put my finger on one area that I consider to be a main problem with the medical profession today in this country from a view as the plaintiff's attorney, this is it.

In talks I've given to doctors and lawyers, they ask me if I would testify in a legal malpractice case. I always say certainly. I don't understand the problem. It's not a personal thing; it's a matter of being professional. Your first duty is to the public and not to your fellow practitioners, whether you're a doctor or a lawyer. It's kind of pathetic when we have to go to New York, California, or Chicago to get a medical expert on an issue. I don't think that a doctor or a lawyer should have to apologize to anyone, let alone his fellow practitioner, for standing up and telling the truth.

I would like to point out to you that a Health Education and Welfare special commission studied the medical malpractice problem in 1973. They made

recommendations in this area. They know that there has been a problem in the past. The commission recommends that organized medicine and osteopathy establish an official policy encouraging members of their profession to cooperate fully in medical malpractice actions so that justice will be assured for all parties. That obviously is not the situation today. The makeup of the commission was very nonpartisan. It consisted of doctors, lawyers, insurance industry representatives, and government representatives.

I have never seen a problem solved yet by shoving it under the rug, but that's exactly what the present legislative enactments are doing. Arbitration can have a proper place in medical malpractice if the arbitration panel, the rules, and discovery are structured to safeguard the rights of all parties adequately. But if you force through unfairly structured arbitration panels, of course you are going to end up with a loaded deck against the patient. Again I ask you, can our society survive with inherent unfairness in its judicial system? I submit that it cannot.

Limitations on the amount of the awards against physicians for negligence can be set. But this, again, has little to do with the premiums that are paid for medical malpractice insurance. Doctors complain about the contingent fee basis, but they use it when they sue the patient for their fees. If a patient runs a stop sign and hits the doctor and severs his hand so he can't operate, of course the patient owes the full amount of the award.

On the other side of the coin, we have the most affluent members of our society telling us that they should have less responsibility than others. I hear a lot about the price of medical malpractice insurance premiums going up, but the question I always ask, and quite frankly it's not answered very much, is whether the premiums that are paid have any reasonable relationship to the dollar volume of the practice of the doctor. I appeared before a subcommittee of the Iowa legislature on medical malpractice and one of the senators said to me, "Well I have a friend who's an ear, nose and throat specialist and he's paying \$12,000 a year. Don't you think that's unreasonable?" I said "I don't know whether it is or not; what's his gross volume?" He says about \$350,000. So you see that the average premium paid by physicians in this country is still around 4 to 5 percent of their gross, and it is a business deduction. When the ratio starts getting out of line, then I think we'll have a problem.

In the last 25 years medical costs have gone up 850 percent; food costs have gone up 350 percent. And yet medical malpractice insurance dollars, which represent less than 1 percent of total medical costs, is being blamed for these rising costs. I submit that this is a distortion of truth.

#### QUESTIONS AND ANSWERS

QUESTION: How do we resolve the problem of the physician's peers retaliating economically and socially for his having testified? I am a plaintiff's lawyer, also.

MR. BALL: I wish I had mentioned this. My feeling is that the first positive step that can be taken in the area of medical malpractice is to beef up peer review in this country because medical malpractice cases are nothing more than society's objective methods of enforcing standards of care. The only other review of a doctor's work is by his fellow practitioners from the hospital staffs. The hospitals should adopt an independent view because quite frankly they are going to be sued too. This Nork case is a classic example of where the hospital failed to enforce proper standards of review of the medical profession in their review committees. I think that it's going to take courage on the part of a few people to stand up in medical peer review committee meetings and express this idea. I think that it has to come from within the profession and it had better come fast. If it doesn't, it will be hastening the day when we are going to have medicine delivered more economically through huge health care units and the private practice of medicine is going to pass by the boards. With these huge organizations delivering medical care, you are going to have peer review, and it is going to be effective, and we're going to have the availability of medical testimony.

QUESTION: You are familiar with charts, obviously, as all lawyers are. In a long term hospitalization or even a short term hospitalization, there are pages and pages of charts, and when a lawyer does not know whether he has a case, he often looks for the dotting of the "i" and the crossing of the "t" in order to get a general overall effect. There frankly are some members of the legal profession who fish. It's very easy to fish from a hospital chart, and that's why insurance companies and doctors are reluctant to give that type of document to everyone. How should we settle that sort of situation?

MR. BALL: I understand. You presented an insoluble problem except on a case by case basis. The problem you run into is that if I write you a letter and I say I'd like a copy of your records and you don't give them to me, if the circumstances exist which indicate to me that there is at least a good strong likelihood of negligence, I'll probably sue you and subpoena the record because I have a duty to do so. I recognize that you stand a substantial risk. You're damned if you do, damned if you don't, so to speak. But the most important thing I mentioned was to call your lawyer and say, "Hey, call this guy up and explain this thing." Explain to him the background of the medical treatment given. Have him talk to another man in your specialty. I had an orthopedic call me from another county. He was a friend of mine. He said, "I have a helluva problem." He said, "This guy called for my records. What about him?" I said, "What about him? He's a good lawyer. Give him the records. He won't take the case unless there is something there." I asked him, "Is there a case there, Earl?" He said no and he told me why. I said, "O.K. I'll call the guy up and explain to him. Or I'll write him a letter. You write me a letter and set out for me what happened here and why this result was obtained and I'll write this guy a letter and tell him the same thing, but I won't use your letter." We did this. I called the lawyer later and said, "Ed, do you have any question?" He said, "No, I'm not going to take the darn



step  
in  
  
g  
led  
w  
le  
I  
st.  
  
ctice  
iv-  
  
s  
  
t  
  
by  
y  
ances  
  
y  
u  
  
."  
  
ty.  
  
ood  
ng  
  
m  
  
e  
and  
darn

case. I've checked into it and I verified what you fellows have told me." In other words, you have to open up that communication. Put yourself in the lawyer's position.



A DEFENDANT'S LAWYER VIEWS MALPRACTICE

Galen J. White Jr. J.D.  
Boehl, Stopher, Graves and Deindoerfer  
Louisville, Kentucky

I would like to begin my discussion by quarreling with the term "medical malpractice." I think some of our previous speakers have alluded to this term with derision. A couple of months ago a Lexington doctor suggested to me that of all the professions, the medical profession is the only one that has to characterize its tort problems as medical malpractice. All other professions speak of professional liability. Having just renamed the topic of this seminar, I want to talk to you about what I believe to be some particular problems, fully aware that I can't rebut all that my learned colleague stated.

Judge Leibson talked this morning about the Stephenson case and the Nazareth Benevolent Institution case. He talked only about the fact that the decision allowed him to get to the records of the hospital and to all the letters of the doctors that had been written about the particular defendant doctor. He did not mention that he received a verdict of \$2.4 million. That was about 5 times the amount of any injury verdict this state had ever known. If that verdict had come in this year with the contingency reserve fund measures contained in our legislation, it would have wiped out the whole fund through 1980.

I'm not talking about the merits of that particular case, but I think it does tend to show that the insurance companies are reasonable in their protestations against what they call the runaway verdict. They can't rate their insureds properly because they may be sued 20 or 25 years after the policy is written. We got a case the other day from a hospital in an eastern Kentucky county. The plaintiff claims recently discovered malpractice from 3 years ago. He sued for \$2 1/2 million.

If we deal with malpractice solely in terms of insurance costs, I think that is treating the symptom rather than the disease itself. The problem of malpractice is more deeply rooted than that. I'd like to review some of those effects and then tell you about some of the problems inherent in defending doctors in our current legal climate.

First, malpractice litigation has indisputably increased the direct cost of medical care. I'm going to talk later about some procedures that doctors and hospitals now feel they have to employ as a result, not of clinical judgment, but because of law suits and judicial decisions. Second, malpractice litigation, for good reasons or bad, intimidates capable and skilled physicians from performing some high-risk procedures for which they have trained. Increased malpractice litigation also influences the availability of health care in particular locations. Once it was a problem in eastern Kentucky to even find a doctor. Now we have doctors, but they are quite often reluctant to treat problems they may have handled 4 or 5 years ago. One reason is because they feel they may be second-guessed by some expert here at the university. Or they may just find a litigious-looking

fellow coming in the front door. A doctor near Carrollton told me just the other day that he simply will not treat an individual from out of town who walks into his office unless it is a legitimate emergency. He just sends them packing down to Louisville. That's the way a lot of doctors feel they are forced to handle it. Maybe he's making the right decision; maybe he's making the wrong decision. The point of the matter is, that's the way he handles his problem. Finally, malpractice litigation has inhibited, I think, the best utilization of manpower. Many doctors would like to use paramedical personnel to perform routine procedures, but they are afraid to delegate that kind of responsibility.

It's difficult to pick up any magazine, particularly professional journals, without reading the suggested reasons for the growth of medical malpractice cases. The first obvious reason is that malpractice does exist. We all recognize that, but I don't think that's the ultimate problem to be solved in dealing with a great many of our cases. Doctors and hospitals have always inflicted pain and injury upon a certain number of patients. Although malpractice does in fact exist, I think that the frequency of malpractice cases bears little relationship to the growth of malpractice litigation. I've read nothing in any survey or report which has suggested that the growth of malpractice litigation is caused by a deterioration in medical care.

One value of reviewing the reasons for the growth of litigation in the malpractice area is that I think it tells us much about ourselves (lawyers) as it does about the medical profession. There are two basic trends which have caused the increase in litigation. One is the tremendous advance of medical skill in recent years. The other trend involves the growth of patient expectations. A doctor in California noted these trends 20 years ago when he stated that he was not concerned about the future cost of malpractice insurance; he was worried about whether it would be available at any cost. Advances in medical techniques and the increased availability of medical care to more people have inevitably increased the chances of medical accidents or unfortunate results.

Revisionist writers of American history have talked about the politics of rising expectations as a pathological development in this country. I think the same could be said about the rising expectations of potential patients. My experience teaches me that people tend to demand more and more until their demands outstrip what can be delivered. The growing number of informed consent cases, of which we win most, is a good indication of that trend.

This is an age of consumerism. At every turn people are encouraged to assert their economic rights. Public service announcements tell you where to go to file your claim for wage and hour underpayment, where you can file your claim for discrimination in employment, and what to do if you have a bad product. I think this carries over to the mentality of people in dealing with their physicians. While perhaps 25 to 40 percent of our cases involve claims that would have been filed 10 or 15 years ago, the majority of them involve claims that I do not believe would have been litigated 10 years ago. The reasons for this are both

good and bad.

Much has also been written about how the changing nature of the medical profession contributes to the growth of medical malpractice litigation. Writers speak of the depersonalization and fragmentation of medical care. Much of that is true. Researchers in Germany published a recent study which indicated that the average length of any patient visit was less than 3 minutes in that country. I think that's probably also a fair statement in this country. However, the patient doesn't realize what a doctor can accomplish in 3 minutes--how much he sees, how much he hears.

I suggest to you that the medical profession is being singled out as a depersonalized profession when in fact that's what is happening to all of us. Bank tellers work side by side with money machines; the old friendly butcher has been replaced by an anonymous meat cutter. Just recollect intimate Crosley field the next time you climb to your \$7.50 seat out in right field at synthetic Riverfront Stadium.

Consider the changes in the legal profession. There are fewer automobile cases now. Lawyers have time on their hands. They are not intimidated by the mysteries of the medical practice as they used to be. Lawyers are becoming more skilled in handling doctors as adversaries and as witnesses. They have found more doctors willing to testify in malpractice cases. If they don't know one personally, there are services all over this country that will provide a physician who will testify for either side on any subject.

Many lawyers are now filing their malpractice cases for the first time, and so I'm glad that Mr. Ball talked about the obligation of a lawyer to investigate. Some of the cases that are brought into my office reflect an abysmal and total ignorance by the plaintiff's attorney of the physician's responsibilities toward the patient. Often that lawyer represents an unhappy client with bad results. Because of the favorable climate for malpractice cases, he files a suit without anything in his file to establish liability. We've gone back and documented these cases and have found that these are not cases where the lawyer has diligently sought medical records or tried to make contact with the doctor. These are cases where the fellow just had a mad client who filed suit.

I've talked about the problems but I haven't suggested any solutions. They say if you are not part of a solution, you are part of the problem. I confess to being that because I'm paid to defend doctors and hospitals. But I'd like to talk now about the problem of defending doctors and hospitals within the context of just a few legal areas.

You've heard it mentioned that an error in judgment is not a basis for liability because a doctor is not judged by hindsight. This is a nice, easily stated rule of law, but as a matter of practice it doesn't always work that way. Doctors find much uncertainty in anticipating what the courts expect of them. I have no problem with the sponge case or the severed nerve case; I'm talking about the cases that essentially involve judgment, diagnosis, and questions of when to

send the patient somewhere else, when to administer medicine, when to do a test. Those are questions of judgment, and yet doctors are constantly being second-guessed by an expert who looks back from the results to the beginning.

Doctors find it repugnant that a lay court, often supported by uncertain medical testimony or no medical testimony at all, may create criteria for a finding of malpractice. I think that when you start to look at how malpractice develops, you should look at these things: (1) the quality of the professionals involved, and (2) the types of cases they experience.

Teaching hospitals and university centers should always provide a higher quality of care than do rural hospitals and physicians located away from ample libraries and other medical facilities. Yet often they must handle the same types of cases. The fact that variation in the performance of a rural hospital and that of a university center may exist should not imply that the former is guilty of malpractice. Even though malpractice litigation is said to deter negligent conduct, a physician is more often than not unclear about what standards will be applied to him retrospectively, what standards will be perceived by a court and a jury after the whole problem has tried before them.

Take a look sometime at Helling v. Carey, 519 P.2d 981 (Wash. 1974). In that case a Washington court held that as a matter of law a physician was negligent in failing to administer a glaucoma test to a young patient despite uncontradicted medical testimony that it was a universal practice of ophthalmologists not to administer such tests to patients under 40 unless the test was judged clinically appropriate. In that case the doctor tested the patient at age 32 when her symptoms suggested to him that glaucoma should be suspected. She had glaucoma--which he admitted may have been in existence for perhaps 10 years--but which had gone undetected. The court didn't let it go to the jury. They held as a matter of law the testing of underage persons should have been done. That decision reflects to me a good bit of hindsight in a case where a court was overwhelmed by a bad result and unduly influenced by the fact that the test was admittedly simple and inexpensive. As I said, as a result of decisions like this, the physician or hospital is compelled to require procedures or tests that no one on that hospital staff believes is necessary.

Further, a defendant doctor faces not only a detached, retrospective evaluation by the courts of his judgment, but he is also often compelled to justify his actions against a foreign expert whose scientific knowledge is admittedly greater than his and who possesses a deeper understanding of the problem. The case of Blair v. Eblen, 461 S.W.2d 370 (Ky. 1970) was applauded by the University of Kentucky Law Journal back in 1971 as abandoning the locality rule. What really shakes me about that case--besides its holding--is that it followed a decision coming from the same court that decided the Helling case.

The Blair case presents a very practical problem of defending many physicians and hospitals. A respected university expert takes it upon himself not only to describe the course of treatment the physician should have followed but also

to state, often on the basis of very little understanding or experience, his opinion as to the standard of care that should have been expected of that physician in the circumstances in which he found himself. For instance, our office tried a case not long ago where plaintiff brought in a fellow from Boston. He said it was "the universal practice" to conduct a particular test before surgery in particular circumstances. On cross examination he could not name one physician in this entire state or in any surrounding state who performed this "universal" test, and yet that kind of testimony went to the jury.

The plight of the defendant doctor is further aggravated by the contest he has to wage against medical treatises. Last year at the seminar one of the decisions talked about was Heilman v. Snyder, 520 S.W.2d 321 (Ky. 1975), which stated that medical treatises authenticated by an expert or by notice by the court could be admitted as substantive evidence. That decision and other decisions I've seen do not tell the courts how they are supposed to instruct the jury as to the weight to be given to that material. The material cannot be cross-examined. The material more often than not does not state what standard the defendant should have been following; usually it describes only the best possible course of treatment. This material is used, I think, unfairly and without real guidelines for the jury against the defendant.

The retrolental fibroplasia (RLF) cases are also a dramatic illustration of the problems with medical litigation. RLF is a condition which was first described by a physician back in the early '40's. It involves the loss of eyesight in premature infants because of damage to retinal vessels. A lot of theories were advanced throughout the 40's as to why this condition existed. In about 1952 some physicians in Australia and England wrote about this condition and opined that probably too much oxygen while the premature infant was in the hospital shortly after birth could cause the condition. It was not until about 1954 that the first literature in this country came up with the same theory. Yet in two cases in the past year doctors have defended themselves against young adults in RLF cases. One was born in 1952 and the other in 1954. The juries found that they were negligent because they over-oxygenated these children 20 years previously only because it was known somewhere, somehow, at the time that there might be a connection between over-oxygenation and the premature infant. Those cases dramatically illustrate the hazards of trying to keep right up to date in the area in which you work. One child was born in 1952 when the subject was written about only in Australia.

I'd like to talk now about some helpful hints to doctors. Here are some areas in which I think doctors can help themselves in their practices. One is the area of consultation. Some of the cases that trouble us most are cases where either the patient or a member of the patient's family has requested consultation. The principal doctor says there's no need for consultation. This may be all right, but he makes no chart of the request or of his reasons for denial of it. It's my humble opinion that when you have a case, particularly a serious case, and a relative or the patient asks about having another doctor take a look at him, that

you should give that very serious thought, and if in your medical judgment it is not required, you chart that.

A second area concerns what choices you should give a patient in terms of tests or procedures. If, in your medical opinion, you believe a test should be made right now, you should have it done right now or have a good reason for not doing it. There's no better way to stick your neck out than to have that patient never come back when you're on record as having stated that at some point in time this should have been done. Never say to the patient that the test should be made now, but that you don't have to do it now. You should keep quiet rather than do that.

Conversely, if the patient suggests that he ought to have a test--an EKG or whatever--and you don't think it's necessary, chart it. Sometimes they're setting you up, but more often they ask innocently. If the person was concerned enough to want this particular test, put it in your chart as to why you didn't do it.

Informed consent cases present the same questions in terms of your charts. If you are a surgeon, do not rely upon hospital consent forms. It is my belief that in questions of informed consent, you should have your own consent form or your own chart where you put down that you told the patient the risks, the possible consequences. Also include the time of day and the date of your discussion. If anyone besides you and your patient is present, make a note of that person.

Finally--and this should be obvious to you--beware of the telephone. Doctors probably practice more bad medicine over the telephone than at any other time. I want to tell you about what happened to a fellow in Florida. In that situation an individual came into a drug rehabilitation center which had no physician on duty at the time. The defendant doctor was sick at home and he wasn't even a member of the center's active staff; he was on the courtesy staff. Someone from the emergency room called him and said they needed a physician's signature on their records in order to admit this patient. He said, "Go ahead and use my name, but I can't treat him." The center admitted him and 4 days later he died-- 1 day after meningitis was diagnosed. The survivor sued the doctor, and the trial judge granted the doctor a summary judgment. The Court of Appeals reversed and held the case should be tried before a jury on these issues. One, whether the physician had accepted the man as a patient. Two, whether he was negligent in admitting the patient without seeing him. And three, whether the doctor's failure to diagnose meningitis was the proximate cause of death. That's a tough case. I think the next time you practice over the telephone you should keep that case in mind.

Just a few more points. I'm a defense lawyer but I have no problems with contingent fees. I think people have to go this route. If the lawyer is willing to take the risk of losing, as they do in most cases, that's an appropriate way to compensate as long as the percentage arrangement is not unconscionable.



A lot of doctors, when they first get sued, want to file a countersuit. The basis for the countersuit usually is, "I didn't do anything wrong and this is frivolous." Well, if it is a frivolous suit, the doctor has a legitimate right to complain. But my question is, why should this be limited to malpractice suits? When a lawyer signs a pleading and certifies that the complaint is filed in good faith, there are sanctions in any bar association, which to my knowledge have never been enforced, against a complaint not filed in good faith. On the other hand, I can state to you that some of my colleagues are looking for a good set of facts to establish a cause of action against the filing of a frivolous suit. We'd like to do it in a malpractice case, but such an action should not be limited to malpractice cases.

The last thing I want to touch on is the problem that often exists between the defense lawyer and the doctor. The reaction of a lot of doctors when they get sued is one of being hurt. This sometimes goes away after the first case, but often it never leaves. That's understandable. However, the only way a case can be defended is for there to be complete confidence and trust between the doctor defendant and his lawyer. The doctor must never hold back, the doctor must level with his attorney. It's unlike any other professional relationship that I know of in the tort field. A doctor is personally and professionally wounded, and a defense lawyer always has to take that into account.

#### QUESTIONS AND ANSWERS

DR. LEMON: Mr. Ball, I've seen you taking copious notes over there. Would you like to destroy your adversary now in public?

MR. BALL: One of the things I did want to mention was the locality rule. That is the rule that has historically required a physician who is familiar with the standards of practice in the locality where the malpractice occurred to testify. It has been pretty well abrogated, and now it's more or less universally recognized that there are national standards of practice of medicine. This is particularly true, with today's ease of communication, when a doctor in Lexington, Ky. can call various national health services or for that matter physicians who are highly specialized in the particular area of the problem and consult with them on the phone. He can call Mayo Clinic, which has that type of service, and hopefully get some insight. Or he can refer the patient somewhere else because of the ease of transportation. Therefore, it has been my observation that the locality rule is more or less a legal fiction. The fact of the matter is that physicians travel to seminars all over the country to learn the proper standards of medical practice in given situations.

As far as defensive medicine is concerned, I certainly admit that this is a problem. The question lies in the degree and the nature and the scope of the problem. A Duke University study authorized by HEW indicates that it is not a substantial factor in the increase of medical costs. Several of my friends have indicated to me that although they feel it can be a problem, particularly among the

unsure physicians, that basically investigation is the name of the game. The proper tests and procedures make a differential diagnosis; therefore, their job is to practice good medicine irrespective of the fear of suit. I think that lawyers and doctors are professional people, and it takes courage to practice any profession properly.

You brought up the matter of countersuits by doctors. You can tell them you got this from the plaintiff's lawyer. The real problem in terms of medical malpractice suits does not lie in the filing. The filing often represents something done from necessity, hope, or a possibility of success when the true facts cannot be made known until the discovery process is made available to the plaintiff. If that information is obtained and if it appears there is no likelihood of success then for the attorney to continue to prosecute the suit up until trial raises serious questions. I think the attorney is much more vulnerable by doing that than he ever will be by filing the suit.

DR. LEMON: Would you like to respond to any of that, Mr. White?

MR. WHITE: No thank you.

DR. LEMON: Are there any questions from the audience? Would you like to have any of these points pursued a bit further?

QUESTION: I have a question about some of the legislation that is being proposed concerning expert witness of the locality, especially in the state of Illinois.

MR. BALL: I alluded to this. Basically this legislation is designed to make it more difficult for the plaintiff to present his case. It doesn't have anything to do with the realities of the medical practice in this country. There is, as I mentioned, a reluctance of in-state physicians in the state; usually the plaintiff experts come from without the state. Consequently, if you limit expert testimony to an Illinois expert, then, of course, you cut down the number of medical malpractice suits. But I submit that this is no answer; eventually, this type of tactic will fall by its own weight.

MR. WHITE: I'll make a comment about that. I share the view that this is a very bad piece of legislation. We should not artificially construct limits on the nature of testimony of people.

QUESTION: I have a question which apparently no one wants to bring up. Given an injured patient and a truly legitimate malpractice act for which that patient is eventually compensated, how much of the judgment can that patient reasonably expect to receive? What's the average?

MR. BALL: I believe the HEW studies concluded that the average attorney fee in these cases is a third. I know there have been citations of fees going up to 50 percent. I don't subscribe to that. I don't do it. I don't think it's right. If the case is so bad that you have to take 50 percent of it, you probably should take it anyway. My own experience in these matters indicates to me that anywhere from 25 percent to possibly, in an unusual case, 40 percent of the net recovery is fair. I might add, too, that I have not in my 20 years seen any real abuse in this area. I'm sure there have been some, but in my own personal

experience I haven't seen it.

DR. LEMON: Is there a related question at issue? It seems that I have read that of all the money that is spent for malpractice purposes--coverage, insurance premiums, cost of defending the actual awards, etc.--that the client who is injured actually ends up with less than 10 or 15 percent.

MR. WHITE: I started to put that percentage in my talk, but I thought it wouldn't sound right no matter how I said it. I think it's substantially in excess of 10 percent. It probably is around 20 or 25 percent. But that includes--and you can play with all these figures--the cost of defending every case that's filed. As long as a file stays open in a claims office, it costs money. The figure of 20 or 25 percent represents payouts to people who won their cases, as compared with all the other costs of maintaining the organization.

DR. LEMON: That might possibly raise some question about the system.

MR. BALL: I was going to say I don't agree with the 25 percent figure. By my recollection it is 40 percent or so, but that is still a shocking figure when you throw it out. But again, you have to get under the surface to really analyze the situation, and it does bring into play the question about the efficiency of the system itself. By the way, I agree wholeheartedly with Galen that we shouldn't call these suits malpractice because the term connotes a bad doctor. That's a bunch of nonsense; it isn't true. The problem you have is that the doctor has the right to refuse to settle and many times--I don't say always--the companies will play upon the doctor's emotional state and, in effect, waltz him into a defensive stance that on the day of the trial he doesn't want to be in. Consequently, they turn around on him and counsel settlement on the day of trial when they should have counselled it before the suit was filed. I think this is bad practice and I think these people have expertise enough that we should be able to analyze the cases quickly, and if the people are reasonable, get in and get out. I tell people to be very reasonable in their settlement demands in this area.



## AGENCY REGULATION

Harry N. Peterson, J.D.  
Director Legislative Department  
American Medical Association  
Chicago, Illinois

The subject of agency regulation, the law, and the professions can be approached from a number of perspectives. Certainly, one approach is from the viewpoints of the professions which are represented here--the physicians and attorneys. Another angle could be from the viewpoint of the economist, insofar as regulation may be responsive to forces operating in our economy such as the pressures which are exerted by strong inflationary trends. Other approaches could be from the viewpoint of the consumer who is concerned, or from the standpoint of government itself, with its increasing role as a main purchaser of health services. It would be impossible, however, to cover the subject fully from these various viewpoints within the time frame of this presentation. Likewise it would be impossible to discuss in depth the reasons, whether real or merely alleged, for the extensive regulations which have engulfed the health care field. Rather, this presentation will accept the existence of such regulation for the purpose of portraying the vast scope which it has developed over the last 10 years. I will also talk about some regulatory proposals currently being considered in Congress. These indicate very strongly that regulation in general will not diminish; it can only increase.

It might be well to know for background that national health expenditures are now at the annual rate of approximately \$118 billion and that they have been steadily increasing over the years. The forecast is that this will continue. Health care expenditures have also been consuming an increasing percentage of the gross national product. This percentage is now pegged at about 8 percent. The heavy intrusion of government at federal, state, and local levels accounts for an ever-increasing portion of health expenditures. With the particularly increasing role of the federal government in paying for health services--and with the resulting heavier demands for services--the overall costs of health care have risen faster than have costs in the economy generally.

These factors along with others have introduced a degree of regulation in the past decade which has not been experienced in the health field before. It has even been said that the health care field may be more regulated by government than any other sector of the American economy. Certainly when we consider the cumulative effect of controls by government at all levels--federal, state, county, and municipal--this assertion becomes less debatable.

Regulation of the health field in its early stages was probably aimed at quality, but today it more and more directly or indirectly affects costs. Because of the nature of medical services, moreover, changes in either cost or quality markedly affect the other.

As we all know, regulation of the professions has been based primarily at the state level. Under our system of government the states have residual authority

with respect to professional licensing and discipline. The controls exerted on the professionals may be either direct or indirect. Licensing would be the most obvious example of a direct control. A host of other controls are found in a variety of laws and regulations affecting hospitals, nursing facilities, clinical laboratories, use of X-ray equipment, drugs, or even disease reporting. Many other could be named. The practice of medicine is also affected by the many laws regulating the practice of its allied professionals.

I think it is fair to say that the great proliferation of regulation has occurred within the last decade or so. This is particularly true at the federal level, but it is also so at the state level. It is often the case that the enactment of a federal program has a direct effect on regulation at the state level. Sometimes the federal enactment specifically requires this. Sometimes the federal law provides a financial carrot for inducement. Sometimes when federal controls fail to be enacted the same controls are enacted at the state level.

I said that the expansion could be marked within the last decade. Another way of saying this is that the acceleration of regulation in the health field probably had its origin with the passage of the Great Society programs of the mid 1960's. The most notable programs were Medicare and Medicaid. While a great many regulatory controls can be directly traced to those programs, a variety of other laws provided the nucleus for more regulation. Laws covering medical education, medical research, drugs, devices, alcohol treatment and abuse, occupational safety and health, neighborhood health centers, health maintenance organizations, comprehensive health planning, to name only a few, all introduce new regulations into the health care field.

The medical professionals simply cannot escape the effects of these regulations and controls. It might be well to look at a few of the federal programs and agencies in order to appreciate the scope of regulations which is being imposed by the federal government. Certain agencies' regulatory activities are to be expected and are indeed beneficial to the public interest. Sometimes, however, agencies seek an expansion of their regulatory activities beyond the authority of the law and create requirements deemed to be either detrimental to the public health or an improper infringement upon medical practice. It is then, of course, that the regulations are of special concern to the medical professionals.

The area of drug regulation is one example. We have seen the reaction of physicians and their professional associations to many recent proposals by the FDA as well as to many recent legislative proposals in this area. The FDA has a longstanding role to insure the safety of drugs reaching the market. Its duty to see that only effective drugs are marketed was added in 1962. Its function of regulating drugs for these purposes is clear and established by the Congress as being in the public interest. However, is it the FDA's proper role to direct how drugs should be used in medical procedures or to prescribe conditions resulting in the elimination of drugs from the market based on relative effectiveness? The FDA does indeed have a right to specify requirements with respect to the labeling

of drugs, but it has no authority to use a regulatory process to mandate how physicians may practice medicine or to dictate the kinds of procedures to be performed with respect to the usage of drugs or devices.

This question must also be raised: is legislation, now being considered in Congress, proper to introduce new and strong regulatory controls impinging on medical practice? For instance, legislation is now in Congressional committees that would specify that drug usage should be limited solely to the purposes stated on the drug labelling. This would contravene long-established medical practice which has enabled physicians to use drugs for the purposes and in the dosages which they in their medical judgment deem to be in the best interest of their patient. Indeed patients could be denied beneficial treatment because physicians might feel compelled by the added threat of malpractice liability to conform strictly to such labelling.

Other portions of the proposed legislation would impose additional restrictions and conditions upon the use of drugs by the medical profession. It would place drugs on the market upon a conditional basis. It would limit the extent of usage of the drug. Certain bills would even limit the availability of drugs to certain classes of physicians.

You can readily see that the thrust of new drug legislation is toward more and more regulation. The corollary result is that professional judgment yields to new regulations. The science, art, and skill involved in true medical practice could be reduced more and more to ministerial functions by regulation. A number have recently enacted modifications in their former ant substitution laws. The prescribing physician is confronted daily with both state and federal regulation controlling the use of psychotropic drugs, including depressants and stimulants.

Medical education is another area which will undoubtedly experience increasing federal regulation. Federal assistance to medical schools was originally aimed at the production of manpower to meet the nation's health care delivery demands. Since the enactment of that legislation in 1963, there has been a steady increase in the number of both medical schools and medical school graduates.

Approximately 13,500 students now graduate from medical schools annually. The number of schools has risen to 114 from the 88 which existed only about 10 years ago. The thrust of this legislation, now that the raw numbers have increased, is shifting to other purposes. While the purposes in some cases may be beneficial, the controls exerted to achieve them are not always desirable. For instance, the funding under some proposals, would be used in numerous ways to require that students upon graduation practice in medical shortage areas.

A proposal which has already passed the U.S. House of Representatives would require every student, after graduation, to repay to the government the money which the school received in his behalf unless the student served in a shortage area.

At this point I might stress that this should be of particular interest to the law profession inasmuch as there are many who hold the view that a mandate of

service or forced payments would be invalid.

Consider also proposed legislation that would create federal standards for licensure of physicians with the intent that those standards would become effective at the state level. The standards would include the actual preparation by the Secretary of HEW of the license examination and would also establish elements as to continuing education requirements. These provisions, while they are a highly improper intrusion of the federal government into state activities, actually represent modified positions. The earlier proposals would have provided for the direct federal licensure of medical professionals.

Another proposal would give control to the federal government of all residency training programs in the country. This proposal would authorize the Secretary of HEW to divide the country into 10 regions and create councils in the various regions. These councils would provide advice to the Secretary, but he would have the ultimate authority to recognize the programs of residency training throughout the country. He would decide where they should be located, and he would determine the number of positions in the various specialties in each one of these programs.

Aside from the extremely serious potential adverse effect upon the quality of training programs throughout the country, the program is objectionable on its face because of the intrusion of federal government into this educational field. Moreover, these proposals are being advanced notwithstanding the fact that the goals which are sought to be achieved through the legislation are in fact already being accomplished today. Recent figures show that approximately 60 percent of all medical school graduates in this last year have entered the fields of primary care--and of course this is the basic thrust of the residency control programs.

Other provisions would eliminate prerogatives which exist in the medical staff. One provision would prevent a hospital from denying privileges to any member of the national health services corps. Certainly, members of the corps must have hospital facilities within which to practice, but at the same time the staff should have the responsibility for maintaining the competency of the staff.

Another provision would enable the Secretary to determine what increases in medical school tuition would be allowable for federal payment. Of course, this would be a new handle of control upon medical education.

National health insurance proposals are also before the Congress, as you know. Some of these would seek to establish programs which would be based upon many existing private sector mechanisms. While all can be expected to result in new regulations, there are some proposals which would clearly impose what would be onerous controls on the medical profession. For instance, some would establish vast governmental bureaucracies to administer the program. We are all familiar with the amount of red tape and paper work that would be generated through such administration. One program would create a strict budgeting process which would freeze the amount of funds that would be allocable in a particular area for a specified number of individuals. This proposal also calls for the setting of



fees, the setting of prospective budgets for institutions, and the establishment of regulatory bodies to oversee the programs with respect to cost, services, and quality.

Two years ago Congress enacted a law which many individuals now see as being of equal or greater significance than national health insurance--the National Health Planning and Resources Development Act. It is currently being challenged in court.

All the ramifications of that law are not fully known at this time, but it takes no special insight to see that it has profound implications in relation to the practice of medicine and the future of our entire health care delivery system. Essentially, it is a law intended to provide for the planning and development of appropriate health care facilities throughout the country. In its many-tiered structure, however, it has created a system of planning which will control all elements of the delivery system. Billed as a program of planning at the local level, the structure in fact gives extreme authority to the federal government and the Secretary of HEW. The planning will ultimately control not only the development of facilities but also the distribution of physicians and other medical manpower. This particular law is an example of extreme regulation through action at the local, state, and national levels. We view it as an example of overreaching by the federal government in the exercise of local authority. The planning process contemplates review of institutional health services to determine their propriety. It also provides for rate regulation, at the present time, in six states.

The Medicare and Medicaid programs have introduced a number of direct regulatory controls affecting the practice of medicine and delivery of care. They encompass such important matters as patient benefits, medical procedures, reimbursement for services, office administration, review of services, and standards for facilities. For instance, the Medicare program of reimbursement for physicians was first set at the 83rd percentile of fees in any of the localities involved. Then it was arbitrarily lowered to the 75th percentile. Moreover, this payment level was based upon data which was already 2 years old before it was put into the formula for determining the fee. Subsequent to this, additional restrictions were placed on the prevailing charge level in the form of an economic index which is established by the Secretary. He determines the components of that index, and this acts as a further ceiling upon any allowable increases in physicians' fees. The controls imposed under Medicaid in many states have been fashioned even more arbitrarily.

All these limitations have produced a discriminatory result by imposing on physicians controls which are not imposed upon other sectors of the economy. A law which created some of these controls, Public Law 92-603, was enacted 4 years ago. Certain regulations which were issued pursuant to sections of that act were so harsh and unfair that unprecedented litigation resulted. These controls included utilization review requirements which acted in a detrimental way to proper

patient care. These regulations are currently undergoing modification.

Other provisions of the law related directly to reimbursement for hospitals. These have also been challenged in the court. The law would permit, for instance, the Secretary to determine certain costs to be unnecessary if he felt the services were not needed in the efficient delivery of health care. Under this provision the secretary made arbitrary classifications of all the hospitals, classifying them by size and location, and then determined that payment at the 90th percentile level would be proper reimbursement. Subsequently, he reduced that figure to the 80th percentile. He thus in effect determined that payments above such amounts automatically constituted services which were unneeded in the efficient delivery of health care.

I have presented only the surface of a vast reservoir of real and potential regulation. Responsible individuals are now calling for relief and deregulation. It is even becoming a campaign theme for the forthcoming election. As a reaction to the regulation imposed on the public and the profession, the federal government has recently enacted some laws which themselves recognize the pervasiveness and the influence of these regulatory agencies. Two of these laws--the Privacy Act and the Freedom of Information Act--attempt to require that only certain information pertaining to individuals be collected and that the information be subject to notification of the individual.

The Congress has also recognized the problems of a massive bureaucracy by establishing a federal paperwork commission. This commission is charged with investigating the amounts of forms and paperwork which are required from the public by regulatory agencies. This commission is currently in the process of holding hearings around the country in order to hear from the public with respect to this. Other responses by the Congress are represented by pending bills which would in effect wipe out certain regulatory agencies unless they could periodically justify themselves and be approved by Congress within a certain period of time. This certainly is a novel approach. It represents a reaction by the Congress. I understand that Colorado has enacted a law which would provide for this objective.

All of the latter may be encouraging, but it may perhaps be too late to reverse trend of regulatory agencies to control our lives. Indeed, when the attempt to reform the agencies are compared with the number of bills presently pending which in one form or another would increase that bureaucracy and would increase the number of regulatory agencies and their power, one cannot help but believe that Congress will continue in its enthusiasm for enacting more legislation effectively expanding the agencies.

In closing I should say that I recognize that I have dealt almost exclusively with regulation at the federal level. As much or even more could be said about state activities. Enactments are now proliferating in the fields of continuing education, licensure, discipline, malpractice, drug usage, certificate of need, HMO's, and comprehensive health insurance; all of them have the cumulative effect of further regulation of the profession. I recognize also that I have

dealt almost exclusively with the medical profession, but I'm sure that you can see the potential applicability of regulatory measures to the legal profession.

hospitals.  
stance,  
services  
ion  
ng  
entile  
o the  
nts  
very

ential  
tion.  
ction  
rn-  
ness  
racy  
be

y by  
h  
e public  
ling  
o this.  
d in  
justify  
s  
[  
ective.  
to  
e attempt  
ing  
ease  
eve

clu-  
said

ificate  
mula-  
I have



UNJUSTIFIED REGULATION: WHAT RECOURSE? WHAT RESPONSE?

B.J. Anderson, J.D.  
Assistant General Counsel  
Office of General Counsel  
American Medical Association  
Chicago, Illinois

I've been with the American Medical Association for almost 12 years now, and I was with them in 1965 when Medicare was enacted. Basically, at that time, the AMA was an adversary to the government. The position of the AMA in terms of its relationship with the federal government shifted from that of an ally to that of an adversary at approximately the same time as the Truman administration came in.

During the first few years following enactment of the Medicare and Medicaid programs, government needed medicine and therefore government was willing to talk to us. They had to rely upon the expertise of the medical profession, the hospital administrators, the private health insurance carriers, the Blue Cross-Blue Shield plans, and others because they had a great deal of work to do if this gigantic program--which would be small in comparison to national health insurance--was to be implemented and if the benefits were to be available to those people for whom they were intended.

After the program became entrenched as the law of the land, many of its predicted undesirable features became apparent. Its fundamental design required the federal government to write a blank check at the beginning of the year without knowing what the total costs would be until after the close of any given fiscal year. The programs were also imposed as we were coming out of some of the population boom effects of the end of the Second World War, but no provision was made to cope with increasing deficiencies in the supply of medical and health manpower and hospital beds. As a result of this limited supply and the tremendous increase in demand, a fantastic escalation in the cost of health care occurred in this country. Government never takes responsibility for this kind of activity, of course, but someone had to be responsible. Physicians and hospitals have thus been the primary scapegoats of the program. There seems to be little that the medical profession alone can do to correct that kind of public preception.

As regulatory processes continued and as HEW had to respond with increasing frequency to the demand for some kind of cost containment, we began to be aware that you can become highly frustrated when you have to deal with Congress. But you can become even more frustrated when you are dealing with the regulatory bodies that are responsible for the implementation of these programs both at the federal and state levels. In the case of the federal agencies, this comes about for a relatively simple reason. Secretaries of Health, Education, and Welfare come and go, but in the background in the regulatory agencies are those career people. Some of them are the Roosevelt era's young brain trusters, some of whom were primarily responsible for part of the initial draftsmanship that brought together the Medicare program. They can be highly selective in what they tell

the Secretary of Health, Education, and Welfare or the top echelon in the administration of their agencies about our needs.

As the decade following the implementation of Medicare proceeded, we at AMA were frequently faced with a hue and cry--sometimes from the ultra-conservative physicians and sometimes from the ultra-liberal physicians--that "they can't do that to us. That's directly in violation of section 1801 of the Medicare law. Section 1801 is used by some attorneys to introduce a speech in order to be humorous because it says that nothing in this title shall be construed to permit the federal government to control the way in which medicine is practiced or the way in which hospitals or other health care institutions are administered, or to interfere in the contracts that hospitals enter into to carry out their business activities. This, of course, is the kind of statutory language that is observed only in the breach.

Many times it would have been tempting to file a section 1801 suit against the Secretary. Even if you work for the AMA, you still have certain responsibilities to your client. It is very rarely that you can succeed in challenging regulations, whether at the federal or state level, because regulations can be changed at any time. You can be out of court before you really get a foot in the door because the Secretary can issue a new set of regulations which make every legal issue that you raised in your complaint moot.

In addition, most lawyers, and I think many physicians, are becoming increasingly aware that lawsuits are not won on legal issues alone. In order to have a respectable chance of success in a courtroom, you must also be able to raise certain social issues with which the public, and therefore the judge, can relate.

At one point we felt that the ideal lawsuit had come along. It was based on a set of utilization review regulations under the 1972 amendments to the Social Security Act, promulgated by the Secretary in final form on November 29, 1974. What coalesced to bring this about? There were a number of factors--specifically three sections of the law. One provided that each case of hospital admission of greater than 60-day duration must be reviewed. The penalty for failure to implement this kind of review in a state Title XIX program was a loss of up to one-third of the federal matching funds for the state's Medicaid program.

A second provision provided that Title XVIII and Title XIX utilization review plans must be the same. In other words, if you have a hospital that is certified to participate in Title XVIII and certified to participate in Title XIX only one style of utilization review plans should be required. You shouldn't have two different systems for performing utilization review in the same hospital.

The third section dealt with Title XVIII. It said in the event that the Secretary found the utilization review plan imposed by the state for the Medicaid program superior in its effectiveness, he could require the state to also use that plan for its Title XVIII program. Simultaneously, the Secretary issued Title XIX regulations and said that he found the Title XIX ones superior in their effectiveness.

ness.

There are 7,000 hospitals in the United States. Almost all of them are certified to participate on either Medicare or Medicaid, and the majority of them in both. The figure runs at around 6,000 hospitals. The total number of hospital admissions per year in the United States is a phenomenal figure. These sets of utilization review regulations would have required each admission which was eligible for benefits under a federal program to be reviewed within 24 hours of admission. The review would then have to be completed within 48 hours at the latest, so that in effect you had a committee decision as to whether or not hospitalization was medically necessary.

To the uninitiated, "medically necessary" is strictly a term of art; it does not mean medically appropriate or medically justified. It means reasonably necessary in order to restore the patient as a productive member of society. It is a somewhat artificial concept when applied to the over-65 age group of the population, who are the primary beneficiaries of the program.

We filed suit in the Northern District of Illinois. We were fortunate to draw an 80-year-old judge who once sat in a wheel chair outside an X-ray department for 4 hours waiting to be X-rayed. He decided that it was a physical impossibility for a committee to decide whether or not hospitalization would be medically necessary within that 24 hour period because they wouldn't even have the test back in that amount of time.

The government did not believe that there was any possibility that the court would issue a preliminary injunction to halt the enforcement of these regulations. As a consequence, Judge Hoffman, who recognized that the Secretary could at any moment remove the objectionable provisions in the regulations to make the lawsuit moot, was amazed that Secretary Weinberger refused to talk to anyone before the decision was reached. The government then appealed to the Court of Appeals. This was a surprise because the issue on appeal was so narrow. The substantive issues of the lawsuit aren't met when only a preliminary injunction is ordered. The burden is to show that injury has occurred, or that there is immediate threat of injury for which there would be no adequate recourse at law. That was not such a difficult burden for us. On appeal you only ask whether or not the trial court abused its discretion in issuing a preliminary injunction. Rather than use the attorney from the U.S. Attorney General's Office in Chicago, the Justice Department sent up one of their big guns from Washington to argue. The Court, however, upheld Judge Hoffman's granting of the preliminary injunction.

One of the noteworthy things in Judge Hoffman's opinion was that he said section 1801 does in fact place a limit on the exercise of the Secretary's authority that the Secretary has been given. Regulations are unreasonable if you can demonstrate to the satisfaction of the court that they do in fact constitute federal control over the way in which medicine is practiced.

Judge Hoffman was particularly impressed with testimony by physicians that one of the primary considerations in making a decision as to whether or not a

patient needed hospitalization would have to be a consideration of the patient's fear of a committee decision that the hospitalization was medically unnecessary. The patient would then have to be out of the hospital within 24 hours because that is when federal benefits are cut off. That can be a very traumatic experience, particularly to an older person who fights going to a hospital in the first place and then is suddenly told he doesn't need to be there.

Judge Hoffman, I suppose, felt very strongly that when government sees a problem, their solution is often geared wrongly to the masses. When a physician sits down with a patient, there is an individual with very unique problems and his concerns should be directed to that. When a lawyer sits down with a client he has to same kind of relationship. Not all federal judges, of course, are so inclined. Some of them are products of the Great Society days and believe that when government sees a problem and devises a mass solution, it does not unnecessarily harm a class of individuals.

After the preliminary injunction was upheld, Secretary Weinberger left and Secretary Matthews came in. Judge Hoffman made it clear that if we didn't sit down and talk to Matthews, we would go to trial on the merits within 2 weeks. Matthews was going to be unable to arrange that but Hoffman said, "Very well, I will schedule trial on Monday." Matthews then met with us on Friday. We were able to establish communications with him.

That in itself was really our victory--we could now talk to HEW. We may not always be able to reach a common understanding, but at least we can talk to one another.

The second victory came when, without our request, Congress revised one of the sections of the 1972 amendments upon which the Secretary had relied in promulgating the first of the utilization review regulations so that there would be no mandate for review of each hospital admission. The language now says "review or screening" and it also includes language that permits this to be done on a sample basis. The language does go on to suggest that a sample could be 100 percent, but there is still room to breathe now.

There are other instances, however, in which litigation has not been as successful. When the 1972 amendments to the Social Security Act were enacted, some people thought that PSRO meant Please Stand up and Roll Over--it means Professional Standards Review Organization. One of the groups of conservative physicians who felt very strongly about this instituted litigation in July 1974 to contest the constitutionality of this statute at a time when there had been no implementation, when there were no regulations, and when there were no Professional Standard Review Organizations yet designated. There was very little hope of being able to demonstrate to a court that there was either injury or such immediate threat of injury that there should be relief from the PSRO requirements. A three-judge federal district panel found that the law was constitutional on its face. The United States Supreme Court affirmed without opinion the three-judge decision. Government attorneys now interpret that to mean that the Supreme Court



has ruled that the federal government has a constitutional right to require physicians to perform peer review. This shows you the difference between the workings of man's mind inside the government and the workings of man's mind outside the government, because I don't believe any self-respecting lawyer would come up with that kind of interpretation.

We are involved in another lawsuit against the Secretary of HEW for much the same reason that we became involved in the utilization review suit. This is litigation contesting the validity of maximum allowable cost regulations, which limit federal reimbursements for drugs available from multiple sources to a maximum allowable cost established by a review board.

In order for physicians to rely upon this regulatory system the Food and Drug Administration would need a current capability to determine the therapeutic equivalency of any single drug which is made by more than one manufacturer. This means that you are talking about drugs available under brand names and generic names, from large manufacturers and small manufacturers. I don't know any physician--unless he is employed by F.D.A.--who believes that the F.D.A. has ever demonstrated to the American public that it has such capability.

Again, this kind of regulatory system requires physicians to keep in mind things other than medical considerations and clinical experience when they prescribe a drug for a patient. To give a good example of how this coerces physicians, think about a pharmacy and therapeutics committee in a hospital which is dependent for 40 to 60 percent of its total cash flow on the Medicare and the Medicaid programs. If the federal government reimburses for drugs at a maximum allowable cost, the hospital will make certain that the shelves of its pharmacy are stocked with those drugs. This means that your pharmacy and therapeutics committee, which comes up with the formula which governs the drugs you may prescribe to your hospitalized patients, will not have the range of choice that was available.

We don't anticipate being successful in this suit, I might add. It's gotten pretty muddled up because the Pharmaceutical Manufacturing Association (PMA) and Kenwood Pharmaceutical Company both filed separate suits in the District Court in the District of Columbia to contest the regulations. Because of the first-filed rules in federal court, the government moved for either a motion to dismiss or a motion to stay the Washington, D.C. suits pending determination of the Chicago suit filed by the American Medical Association, because we filed before they did. We had waited until they clocked in the proposed regulations at the Federal Register and then had rushed over to the court house so we would have the right to say we filed first. We know about the first-filed rules, you see.

Consequently, after PMA got thrown out in Washington they came into the Chicago suit, intervening as a co-plaintiff with the American Medical Association. That was followed by the states of Massachusetts and Connecticut intervening in support of the federal government.

It's been interesting because even though Massachusetts is a co-defendant

with the government, the director of the Title XIX Massachusetts Medicaid program joined with nine other directors of state Medicaid programs in signing a petition asking the Secretary to delay the effective date of the maximum allowable cost regulations because they would be unable to implement them for another year. It's a case of the right hand not knowing what the left hand is doing.

The most recent litigation in which the AMA has filed a petition is a suit initially filed by the state of North Carolina. It concerned the National Health Planning and Resources Development Act of 1974. From the very beginning, of course, we've said that this is the most massive piece of bureaucratic control that has ever come on the American scene and that it deprives the states of their 10th amendment rights. The ideal plaintiff for this suit is North Carolina because their Supreme Court said 4 years ago that a certificate-of-need law violates the state constitution. No attempt has been made to introduce subsequent certificate-of-need legislation in North Carolina partially because their state supreme court insists that to do so, they would have to amend the constitution.

Even if we don't win, I think that certain things will be accomplished. One will be that the implementation and development of the programs under that law will be undertaken with much greater care. There is a strong possibility, if North Carolina gets the three-judge court convened, that a number of other states will have an interest in joining this litigation. If even 5 or 6 states contested the constitutionality of this kind of law, you might see a very good reaction from Congress.

I really don't have any particular conclusions in terms of how to challenge new regulations. There is an apparent push in the legislatures to get their teeth into the kind of problems for which the public is crying for solutions. The future will show to an even greater extent than the past that the construction of health care delivery systems and medical programs will continue to lie with the courts rather than the legislature or the regulatory agencies. In Chicago you see bumper stickers that say, "Help support the lawyer; send your son to medical school." If you can't get your son into medical school be sure to send him to law school, because there's going to be an awful lot going on out there.

#### QUESTIONS AND ANSWERS

QUESTION: It seems to me that every time an inspector or regulator opens his mouth, it costs the government, the institution, and/or the patient more money. Has a study ever been done regarding cost effectiveness of regulation? Does it accomplish its purpose and does this accomplishment of purposes justify the cost?

MS. ANDERSON: There have been a number of studies done by hospitals on the cost of the utilization review system. The figures run from \$13 per patient to \$7.10 per patient. These cost studies are based upon the supposed requirement under both the Professional Standards Review Organization and the utilization review regulations that you retain nurse coordinators to do the initial screening against the criteria developed by the medical staff. The answer to your question depends

upon your audience. To the government, it's mandatory that we have them. To the public, who never really understand that they are the ones who pay the added costs for their hospitalization, the regulations aren't unnecessary. To the consumer advocate, we've failed utterly; they want more controls. You have to pick your audience if you want the right answer.

MR. PETERSON: I'd like to add something to that. It was very notable when various programs were considered in the Congress that there was an extreme lack of reliable projections as to costs. No one talked about what the overall cost would be. They talked in terms at that time of the need to do something, but the questions as to effectiveness and cost-benefit ratio that might be derived got lost in the shuffle. There were some very high costs for the program. I think some of those figures are now being borne out as the program is being implemented. Just to use the PSRO as an example, while it is not even fully implemented at this time, the law requires the designation of PSRO areas around the country. About 200 have been designated, but that's only about one-fourth of the total. Already the Congress is beginning to ask questions concerning what they have created, the cost of the program and its effectiveness. Unfortunately this has been a typical history in the legislative process.

QUESTION: It seems to me that I have read that some of the council members in the AMA were not too much opposed to PSRO because of some funds being filtered from HEW into the program.

MS. ANDERSON: The policy statement on PSRO by the AMA, just like all other policy statements, came about by majority vote of our House of Delegates. The House of Delegates initially said that PSRO is the law of the land; therefore, if ever it is to work so that it does not interfere with the way in which physicians practice medicine, then medicine should take a leadership role in trying to shape it. Not all physicians necessarily agree with that. The \$1 million was an HEW grant for the development of review criteria so that there would be adequate professional and medical specialty input so that physicians could work with the regulations. The AMA did not derive any benefits from that \$1 million, except the headache of having to work with the committees.

QUESTION: I probably badly misunderstood something that Ms. Anderson said. I don't understand the mechanism of this fight. I understood you to say it was impossible to fight regulations until they were written. Then in the next breath I thought you said that you have no access to regulators and no way to control them. Did you mean you had access to or some control of regulators or regulations only through the courts, and that there was no use in fighting the law of the land? The AMA's position in influencing legislation before it is enacted is confused to some physicians.

MS. ANDERSON: We have always used our persuasion and education prior to the enactment of legislation. We have always attempted to use the same tools to shape the way in which regulations will be promulgated. When Casper Weinberger was Secretary of HEW he would not even answer a phone call from the AMA. As

nearly as we could tell, he paid no attention to any single written document. It was really a point in time when you found that persuasion, education, written document, and offers to be of assistance were totally ignored. That's when the utilization review suit was filed. We now have Secretary Matthews and Dr. Theodore Cooper as Assistant Secretary, and so we have good communications with the regulatory branches in HEW. If we were to have another breakdown in communications, then that would be one of the factors that might enter into a decision to file litigation, but there are many other factors that enter into that decision. We'll never stop trying to have direct input into the shaping of both legislation and regulations.

MR. PETERSON: During the first session of the current Congress, the AMA either through appearances before committees or statements of letters in response to proposed regulations, appeared about 80 times. This year's activity seems to be going at about the same pace. The association, in its responsibility to the public with respect to the health program, continues to be active both before the Congress and HEW.

QUESTION: The Kentucky Peer Review Organization has been tentatively designated as the PSRO of Kentucky. The hospital I work for has been designated a pilot hospital. They told us this about 2 years ago. What is the current status of PSRO as far as the individual states are concerned? My understanding of our utilization review criteria is that they are much the same as those that the AMA had the injunction against, but that we still have 24-hour review in this type thing.

MS. ANDERSON: You should remember the differences in the underlying statutes. We contested utilization review regulations in which the underlying statutes did not authorize the Secretary to require 24-hour review. However, in the language of the Professional Standards Review Act, there is specific authority to require PSRO's to conduct prospective review, concurrent review, or retrospective review. So there is a great difference, from a legal viewpoint, in the way you would view the two programs.

MR. PETERSON: There is one other aspect to that. In many areas the PSRO program is not organizational even at this point. However, the utilization review programs which have been in effect in the hospitals continue. There is in the PSRO law itself a mandate that where the PSRO finds the hospital's utilization review program to be effective, it is required to use that mechanism as the vehicle of utilization review. That is not to say that the requirements of the PSRO cannot be imposed upon that review system at another time.

Another factor relates to the cost of the program. Inasmuch as the appropriations by the Congress were inadequate to fund all the PSRO programs around the country, the Congress devised another system to fund the program. That system provides for funding through the Medicare program. This will augment the development.

MS. ANDERSON: What he's saying is that the hospital has to pay PSRO for parts of

your utilization review. That cost goes into your reimbursement formula under Medicare.

QUESTION: What is the AMA view on the newly-proposed utilization review regulations that appeared in the March 29 Federal Register? Why did AMA stand pat on the issue of whether you had to have a definite diagnosis made before surgery?

MS. ANDERSON: The Association has not submitted formal comments. The last date for comments is June 1. The Board of Trustees reviewed the regulations and felt that there was a great deal more flexibility in them than in the previous one because there doesn't have to be a utilization review on each admission. The criteria for review don't have to be in accordance with national guidelines, which was one of the specific provisions in the older utilization review regulations that we contested. Each hospital medical staff in any particular hospital is given the right under this new set of proposed utilization review regulations to develop a list of diagnoses, conditions, and symptoms that invariably require hospitalization. What the regulations basically say is that pain in and of itself can be enough to constitute an elective procedure that does not require review. One of the other illustrations given in the regulations is abdominal pain that requires further diagnostic testing. This invariably requires hospitalization under these regulations. If, however, an admission did not meet one of these diagnoses, symptoms, or conditions, then a member of the utilization review committee would be required to review that admission within 3 working days. If he felt that admission was not medically necessary, he would then be required to consult the attending physician, who would have an opportunity to explain all of the factors involved in his decision to request admission. If the physician member of the utilization review committee were not persuaded by this, then a second physician member of the utilization review committee would have to go over the information in the chart, the information provided by the attending physician, etc. The process would usually take about 5 working days. Under the regulations, each hospital would establish 5 days per week as working days for the purposes of the regulation.

The additional provision that you were talking about is the one that says in cases of elective surgery or other elective procedures--and this is defined as surgical or other procedures which can be delayed without significant medical risk--the list of criteria is made by each particular hospital. The review would have to be performed within 3 working days, or prior to the performance of the procedure, whichever would be shorter. I'm quite certain that when the AMA submits comments, that there will be comments on that particular provision of the proposed regulation.

QUESTION: Mr. Peterson, you used a lot of superlatives when you described what you consider to be the work of all those boogymen up in Congress. You said that some of the legislation on national health insurance would clearly impose an onerous control and have a profound effect on the delivery of health care and so forth. I'm still swayed by the proposition that legislation doesn't just materi-

alize but instead results from at least what is perceived as a need. Without getting into a discussion of whether or not regulation itself is needed, you seem to be taking a position that the AMA draws the line at no regulation at all. I don't think you mean to leave that impression. Could you tell me what criteria you use to distinguish reasonable from unreasonable regulation?

MR. PETERSON: I don't think you can make a general statement. I think you have to look at each case individually. I did use some terminology as you have indicated, but I also said that agencies have a proper role in making regulations and that regulations are mandated by the law and can be beneficial to the public interest. I also indicated in my statement that those regulations that we felt went beyond the law or were detrimental to the public health would receive special attention from the medical profession. As Ms. Anderson has indicated, when the litigation was filed on the utilization review regulations, the Association took the action in the interest of the public, and we were sustained by the court. However, I would not want to leave the impression that the Association is opposed to all legislation. As a matter of fact, in one Congress, we were there in support of the proposed legislation in 31 instances.

MR. KRICHBAUM: Let me follow that up with one example. Section 1122 of the Social Security Act, which placed limitations on the portion of reimbursement from federal funds to be used for unapproved capital expenditures, used the term "health care facilities." Nowhere in the law does it define what a health care facility is. That's an example of Congress not meeting its effective role. That left it up to the agency to define the term. As a result, the agency came out with a lengthy regulation defining what Congress meant when it used the term health care facility. In essence, Congress writes part of the law and the regulatory agency, which is non-elected, continues the writing of the law. Subsequently, other problems developed when some states attempted to say what the agency meant in its regulations. They try to take it even one step further.

MR. PETERSON: I'd like to make that point a little clearer. In the regulation to which he's referring, the agency included as a health care facility the term "organized ambulatory health care facility." That type of general term was introduced and it created more ambiguities. It was that term that some states then tried to apply to physicians' offices. The net result was that "health care facilities" was later interpreted by the states to apply to physicians' offices and this caused a great deal of problems.

QUESTION: I can understand having difficulty with interpretation, but I think some of your objections were a little more substantial than semantical. I'm in favor of the proposition that the government can impose reasonable limitations on reimbursement for health services that are provided under a public assistance program. You seem to like neither the 70th percentile or 90th percentile figures for reimbursement. I will agree, however, that I can see where you could professionally object to the government trying to tell you how to practice medicine. But in terms of putting a reasonable limitation on reimbursements, I don't understand your objection.

MR. PETERSON: The language of the Act provides for "reasonable charges" by physicians. The question about the regulations is the matter of interpretation. The 90th percentile that you mentioned was a ceiling arbitrarily decided for reimbursement to the hospitals under the program. That was subsequently arbitrarily reduced to the 80th percentile without any justification given for the move. As far as physicians' charges under Medicare are concerned, they originally set reimbursement at the 83rd percentile and then reduced it to the 75th percentile. This was done by regulation even before the law was amended to so provide.

Therefore, I think as attorneys we should examine whether the regulations carry out the intent of the law. We should also look at the application of special economic index formulas that apply to one sector of the economy that are not generally applicable to any other sector. These are questions that are involved.

Carrying it a step further, after the Medicare program established its formulas, the Medicaid program could easily pay a lower fee on top of that. You say that the government should have the right to make reasonable reimbursement for the programs that it subsidizes. That may well be, but when the Medicaid program is paying, 40, 50, or 60 percent of customary charges in the area, the question under the law is whether that payment will reasonably assure that the services are available to all the individuals entitled to care under the program. The question of whether it is reasonable or not, I suppose, is a matter of interpretation. But when reimbursement is set at such low percentiles, I think it bears very close examination.





PANEL DISCUSSION  
REGULATORY IMPACT ON MALPRACTICE,  
CONFIDENTIALITY, CLINICAL DECISION MAKING  
AND OTHER PHYSICIAN/PATIENT REALTIONSHPIS,

Harry N. Peterson  
John A. Krichbaum  
B.J. Anderson

QUESTION: If a hospital utilization review committee decides that a patient's stay is not covered under Medicare, and the patient has to leave the hospital within 24 or 48 hours, and if some harm comes to the patient, is there any malpractice involved in that and who would be responsible?

MS. ANDERSON: The utilization review regulations and the provisions of Medicare law do not require that a patient be discharged because of a decision made by a utilization review committee. What the utilization review committee decision does is cut off federal reimbursement for that hospitalization 48 hours after the notice goes to the patient and the attending physicians. If, for example, a hospital administrator were to tell a patient that he couldn't stay, and if he sustained an injury directly related to that early discharge, then the hospital might incur liability. However, I do not think that hospital administrators do that sort of thing because most hospital policies state that only a physician can admit or discharge a patient. If a physician felt that it was medically contraindicated to discharge a patient, and if he relied upon a utilization review decision, then it is possible that this would be a factual situation in which he could incur liability because liability is based upon knowledge of all of the facts.

QUESTION: In a lot of cases it seems that patients just cannot stay in the hospital because they do not have the money to pay. I know that a negative review decision does not mean that they have to leave the hospital when their physician thinks they should be there, but in practice the patient has to leave the hospital because he doesn't have any money.

MS. ANDERSON: I understand that and you understand that, but you still have to come up with a hypothetical fact situation that is going to result in a finding of malpractice. Is there a typical case in which the utilization review committee says continued stay is medically unnecessary and in which a physician says this patient can't go home? I just don't think those factual situations occur on average. You gave me a hypothetical. What were the contraindications for discharge of the patient?

QUESTION: This patient had a total knee implant put in by me. On the 14th day after surgery the utilization review committee stated that the stay was no longer covered. I felt that this was a dangerous situation. We had to inspect his incision on an hourly basis; it stood a chance to open up. We went through the whole appeal mechanism--there were two appeals involved. On both occasions the utilization review committee decision was sustained. When the patient was almost

ready to go home, the incision separated and they had to cancel the discharge. If this had happened just two or three hours later, we might have been in a difficult situation.

MS. ANDERSON: What the Medicare law contemplates is that a continuum of care will be provided for the patient so that you could have transferred him to a skilled nursing facility where there would be registered nurses to care for the incision. If he had a sophisticated enough family, you could have sent him home and made arrangements for home health services; a registered nurse would have made regular visits for the home for an appropriate period of time.

There have not been any reported court decisions involving that kind of fact situation. Discharging patients is a risk that physicians run many times. You can discharge a patient who has been monitored for 3 days with minimal chest pains and have him walk out the door and drop dead of a myocardial infarction an hour later. None of us are really astute enough to be able to predict with certainty what the future medical course will be.

QUESTION: No, this situation is slightly different. Here the physician himself feels that the patient has to be in. It's the utilization committee....

MS. ANDERSON: Yes, but what Medicare contemplated was that you would then transfer that patient to a skilled nursing facility where coverage could continue because of the registered nurses to observe the incision at the regular intervals.

MR. KRICHBAUM: I think part of the answer is that what you do is going to be measured by the necessary standards. The fact that the utilization review committee has indicated that there's no further need for the patient to stay in the hospital is going to be a very strong indication of the prevailing standard of the community. Beyond that I think you've extended your protection against malpractice by advising the patient of your individual professional judgement.

MR. PETERSON: I think the problem goes a little bit further. It indicates the dilemma in which the physician is placed in many situations. I supposed there's no real answer from the standpoint of liability until something occurs after the decision has been made. For instance, suppose the physician determines in this case that the patient should stay in the hospital a week longer. The patient is able to pay the hospital bill and stay there at the direction of the physician and nothing happens. Then he leaves and begins to think about the decision of the committee that all that hospitalization was not medically necessary. You can see the other side as to what might happen in this age of consumer litigation.

MR. KRICHBAUM: There may be some liability for the additional costs that the patient incurred, but at least you would have adequately responded to any risk of malpractice with regard to injury to the patient had he left.

QUESTION: Can an attorney, when he's investigating a claim of malpractice, secure the information that came before the review committee in order to determine if a claim does exist?

MR. KRICHBAUM: I'm sure that depends to a degree on what you mean by review committee. If it is a non-PSRO, the answer may well depend on whether the state has

a law granting immunity from discovery of peer review proceedings, as many states do. Ms. Anderson says there are 21 states that have such laws. Three or four of those laws also specifically say that they apply to the proceedings of PSRO's. I think that one or possibly both of our panelists might like to comment on the potential availability of PSRO criteria, standards, and norms to plaintiff's lawyers.

MR. PETERSON: The criteria, standards, and norms are already available in published form in the medical and legal community. The question will arise as to whether these standards will meet the ultimate standards of care against which medical treatment is measured in the courtroom. I don't think this has yet been decided in litigation. The organic PSRO law, as I recall it, does not provide that the information of the committee is immune from discovery. The AMA, in developing a proposed amendment to the PSRO law, has recommended protection for this information in order to facilitate the objectivity of the program.

MS. ANDERSON: No one knows. The law had language in it saying that the records and data of PSRO's shall be held confidential, in accordance with regulations issued by the Secretary. The law goes on to say that the regulations will make certain that they aren't so confidential that they cannot be used for proper program purposes. However, the Secretary has not yet issued any regulation. He has taken the position in an initial draft that since PSRO's are agents of the government, they are subject to the federal right to Privacy Act, which means that individuals whose cases are reviewed have access to the review records, it means that an agent of the patient could also have access. However, the Secretary has not addressed the question of whether such records shall be discoverable for pretrial purposes, and there is no case law.

QUESTION: I'm not as familiar with that statute as both of you are, but I read it as a mandate that the Secretary adopt regulations for the disclosure of PSRO information, keeping in mind of course the protection of the patient and doctor. As you say, the Secretary has not done so. Don't you think it would be a fair statement that this kind of information might have an impact on a cost-effectiveness study?

MS. ANDERSON: No one has any objection to making statistical studies from PSRO reviews, but to take the actual minutes of them and make that information generally available tends to harm the general public interest. One of the objectives of this kind of program is to assure the quality of services and their provision in the most cost effective manner possible. To open up records of review committees that are looking at individual cases tends to have a dampening effect upon the objectivity and judgment of doctors of the work of colleagues. On the other hand, statistics are one of the contemplated uses of the PSRO activities.

MR. KRICHBAUM: One of the questions that came up earlier was whether the required publication of a blacklist of physicians who have repeatedly failed to meet required standards of the PSRO will create a larger target for medical malpractice suits. Is this an accurate description of the PSRO law, and if so, are there

adequate procedural safeguards in the law for a physician?

MS. ANDERSON: The PSRO law does require the Secretary to publicize the names of physicians who, in a substantial number of cases, have failed to comply with the norms, standards, and criteria of the PSRO. Dave Willett, a California attorney, has predicted that this will have an impact upon the number of malpractice suits filed for one very simple reason. Once a patient has benefits cut off because of a determination by a peer review committee that services are either inappropriate or unnecessary, he has been directly affected in his pocketbook and would be more inclined to file a lawsuit. I don't know whether plaintiffs' attorneys would agree with that reasoning or not. If you've ever observed the American scene, you know that anything that's going to happen in the courts across the land happened 10 years ago in California. If the California attorneys are saying this is going to happen, then you can predict in about 7 years you'll see your first suit in California. They you'll have a little bit of time before you're ready to defend it in your own court.

QUESTION: I attended a seminar on the Kentucky PSRO organization, and I got the impression that criminal penalties were prescribed for a breach of confidentiality. Could you enlighten me on this?

MS. ANDERSON: The Social Security Act itself has penalties for failure to maintain the confidentiality of certain records that are a part of the Social Security Administration system. When HEW wishes to calm the fears of physicians, they always say there's a criminal penalty if any of the Secretary's agents violate the requirements of confidentiality. But that is a strange and wonderful world because the Secretary at the same time tells the PSRO's that very little of the information they have will be maintained in confidence.

MR. KRICHBAUM: You're definitely not going to be in breach of the PSRO confidentiality provisions if you otherwise engaged in carrying out what the PSRO is intended to carry out. There is conflict in the minds of many physicians that the very functions and duties to which the PSRO is assigned violate basic confidentiality principles of physician-patient relationships. There's a built-in conflict in the law, I think.

QUESTION: You stated that the PSRO utilizes the review committees that already exist in the hospitals. Can you tell me something about the mechanics of the review organizations in each hospital, how they are appointed and of whom they consist?

MS. ANDERSON: The utilization review committee must be composed of physicians who are either members of the hospital medical staff--or if the hospital does not have enough physicians on the staff--a committee of physicians appointed by a county or regional medical society. In the event that neither one of those requirements could be satisfied, some other mechanism acceptable to the Secretary must be used. If you have a hospital with an organized medical staff you could form a committee of three or more of them. A physician who has been directly or indirectly responsible for the care of an individual patient must

excuse himself when that patient's care is being reviewed. The law mandates that the utilization review committee review all admissions of continued stays of patients whose care is federally financed.

The utilization review is also a mandated medical staff function under the standards of the AMA Joint Commission on Accreditation of Hospitals, so that hospitals which apply voluntarily for accreditation by the commission are required to carry out these review functions anyway.

MS. ANDERSON: If more than 10 percent of the physicians in a PSRO area indicate that they object to a conditional PSRO as not being representative of the physicians in the geographic area, then the Secretary must poll the physicians. If more than 50 percent of the physicians that respond to that poll object to the organization being designated as a conditional PSRO, the Secretary cannot enter into a contract with it. The end date for this rule is January 1, 1978.

MR. KRICHBAUM: That doesn't mean you're never going to have a PSRO in such an area. Some other entity will be set up as the PSRO.

MR. PETERSON: If the Secretary cannot enter into an agreement with an organization of professionals within the time limit, then he can enter into an agreement with an organization which is not a professional association afterward. Ultimately, then, there can be a PSRO imposed in the area by the Secretary of HEW even without agreement with the physicians.

MS. ANDERSON: Such a PSRO would probably be comprised of government employed physicians.

QUESTION: These review committees are not usually government employees; they are essentially brother doctors. Is that correct?

MS. ANDERSON: Only physicians have a vote on the utilization review committee. The coordinators; they can collect information and make it easier for the physicians. But the vote as to the lack of medical necessity can only be made by physicians.

QUESTION: Doesn't that make the review committee sort of a rubber stamp of doctors approving the actions of their brother doctors?

MS. ANDERSON: You don't know physicians very well, do you?

QUESTION: Well, I know that when you try to get one to testify against another one, you can't do it.

MS. ANDERSON: Do you know how they solved that problem in California? They have an abundance of medical experts in California because they found out all it takes is money.

MR. PETERSON: A more basic question on utilization review is whether it should be by physicians. But who else is going to determine the propriety of medical treatment if it is not a physician? Are there any suggestions as to who else would do it?

MS. ANDERSON: There are other people in a hospital besides physicians. They have ways of exerting pressure also. Lack of space also plays a role. The best utilization review takes place in those hospitals that have the highest bed occupancy. Where there is a demand for beds, utilization review has always been

effective.

MR. KRICHBAUM: One question raised this morning concerned the extent to which the regulations and legislation have affected the betterment of health care in the country. I think it's a very good question. This is somewhat related to the question of cost-effectiveness. Certificate-of-need laws are an example; have they resulted in any lowering of rates in those states where they've been enacted as contrasted to the states where they haven't? All the information that we've seen indicates that there's been no lessening of rates or of occupancy in states that have the certificate-of-need laws. In fact, the amount of money that goes into the regulatory process may have increased the amount of money being spent in this area.

MR. PETERSON: This general question is one that's surfacing in some of the committee hearings at the present time. The questions that are being asked concern programs that have been enacted by the Congress which are not necessarily achieving their purpose. Of course these programs are relatively new, but questions are being asked as to whether the provision of medical services is most effective in this regard, or whether federal dollars should be spent in other areas of health education related to the lifestyle of Americans? Would that be more effective for the betterment of health generally? Congress is now considering extensive programs with respect to health education.

QUESTION: Would there be any way for the PSRO's to disclose information to that Congressional committee or to other committees other than pursuant to regulations adopted by the Secretary?

MR. PETERSON: I think that the committees, prior to the initiation of the hearings, solicited information from the PSRO's by submitting questions to them concerning their activities. At hearings which took place earlier, it was indicated that some review activities were beneficial in reducing, for instance, lengths of hospital stay. This type of reduction took place in the peer review activities of the profession prior to the initiation of PSRO.

QUESTION: Ms. Anderson made the statement that there was little the medical profession could do to improve its image. I was particularly jolted by the statement that if review results are negative, this causes patients generally to lose confidence in their physician.

MS. ANDERSON: I said that there's very little the medical profession alone can do to change its public image. All of the polls indicate that the medical profession is not held in as high esteem as it once was by the general public, but that individual patients still feel that their physician ranks higher than most any other professional person. The relationship between the physician and a patient is one of trust. A physician has a fiduciary duty to treat his patient with the best interest of the patient in mind. But the public does not perceive the medical profession in the same way that an individual who goes to a physician perceives his individual physician. There's something about the effectiveness of utilization review that many members of the public overlook. That is that there

are fixed costs for maintaining beds in hospitals which continue regardless of whether the bed is occupied, so that in some hospitals, particularly where there is a surplus of beds, the government is really paying increased costs for decreased lengths of stay. I don't think people ever stop to think about some of those things. Physicians alone can never change the way the press perceives the medical profession, for example. That's one public view of medicine.

QUESTION: Then I did misunderstand you. You did not say that the review causes patients generally to lose confidence in the medical profession.

MR. KRICHBAUM: Ms. Anderson suggested we keep our eyes on California to see what's occurring there. One bill that's pending in the state senate out there that physicians view as potentially causing problems is one which would restrict physicians to practice in specialties to which they've been certified by the state. This bill has been kicking around out there for a number of years, but it has recently passed the house. Physicians out there are closely watching that piece of legislation. We may see similar types of legislation being introduced in other states in the coming years.

Would anyone in the audience like to express a view on continuing medical or legal education and whether it should be a required, or whether it's an effective means of improving quality?

QUESTION: My own view is that continuing legal or medical education ought to be gauged to the practitioner. I don't think a physician here at the University needs continuing education as much as a practicing physician in a rural area of the state. I think across-the-board, mandated, continuing education like that takes in a lot of people that really don't get any value from it.

MR. KRICHBAUM: Anyone with another view or opinion on that?

QUESTION: I would think it's a good idea, but the mushrooming of knowledge in almost all fields about makes it impossible for a single individual to comprehend what's going on. We might have to get researchers on our medical staffs to keep the rest of the boys up to date. I've even thought at times that maybe the executive office in the country should be filled by a committee and not by an individual because its getting to be too much for one person to handle.

MS. ANDERSON: It was when God appointed the committee that we got the camel. What is occurring in the field of continuing medical education has been an increased realization that formal courses alone do not answer the needs of individual physicians. There is increased emphasis on medical audit studies as being perhaps one of the more effective mechanisms of assuring continuing medical education in that it is on hospital staff level where you have the best capability of tailoring the educational process to the needs of the individual practitioner.

MR. KRICHBAUM: Maybe the lawyers out here have either fallen asleep or they don't want to say anything on continuing legal education. Do we have some lawyers that might want to comment on that?

MS. ANDERSON: Plaintiff's attorneys do a beautiful job of educating each other as to what are and are not successful trial techniques.

COMMENT: I have not attended every session--obviously I don't have time, I don't think anyone has time--of the continuing legal education programs. I think I would be appalled if the program were made mandatory. I find them to be about 50-50 in terms of value, in terms of content, in terms of any utility that I derive from them.

MS. ANDERSON: Are you talking about your State Bar Association programs?

QUESTION: The Continuing Legal Education programs. It's not mandated in Kentucky.



## PSYCHIATRIC/LEGAL CONCEPTS OF DANGEROUSNESS

Dr. Harvey L. Ruben  
Department of Mental Health  
Connecticut

The problem in dealing with this topic is that, for the most part, legal and psychiatric concepts of dangerousness fail to coincide. My hope is that by the end of our session today we'll both have a better understanding of each other's position. Then we can begin to reconcile some of our conflicting ideas on this subject.

Before I start my presentation, I'd like to give you a small examination. I'm going to present four hypothetical case situations. I'd like for you to respond to them in two ways. First, do you believe that this particular patient is or will be dangerous to himself or others? Second, do you believe that involuntary hospitalization is necessary?

The first case is Jane, a 27-year-old separated social worker who came to me complaining of feelings of depression and anxiety as a result of having recently lost her job. She'd been employed as a supervising social worker in a social service agency in Boston for several years. She stated that because of a personality conflict with her supervisors, she was given the ultimatum of either resigning or being fired. She refused to resign and so her employment was terminated.

She also said that she'd been having many difficulties during the past several weeks while living with her mother. She said that she'd always had difficulty getting along with her mother. These problems had resurfaced. Her father had been bugging her about the way that she had been dealing with her mother. In a fit of anger several days prior to her seeing me, she'd punched her father in the face.

During several weeks of treatment, she continued to have symptoms of anxiety and depression. There was also some evidence of impulsive behavior. She was continually preoccupied with legal matters in relation to initiating a grievance procedure with her former employer and in relation to her forthcoming divorce. During a period of 3 weeks she hired and ultimately discharged three different attorneys. She also became very angry with me on several different occasions. She fired me once only to return the following day and ask if I would continue to treat her, which I did.

Attempts at stabilizing her behavior by using medications were unsuccessful. She claimed that she experienced unpleasant feelings from the medications and refused to take them. She said that she felt better, but she didn't appear to be better.

Eventually, in the middle of a group session, another patient made a simple comment to Jane that she had undoubtedly played some part in her own firing, and Jane became exceedingly angry. She started screaming at this particular patient. When I attempted to make a comment to help alleviate some of her hostile feelings, she became quite angry at me. She continued to scream and then ran out of the

office.

Please consider Jane's case in light of the questions of whether or not she is dangerous to herself or others and whether you believe involuntary hospitalization would be in order.

The second case is that of John, a 24-year-old single male who received a medical psychiatric discharge from the Marine Corps for a psychotic thought disorder which he developed in Vietnam. His diagnosis from the Marines was paranoid schizophrenia. He came to me about a year after his discharge when he became dissatisfied with the services he was receiving at the local Veterans' Administration outpatient clinic. During about 6 months of treatment, John showed an inability to handle closeness with anyone. He consequently had a difficult time maintaining a job. During several different jobs he repeatedly complained that people he worked with were out to get him or attempting to control his thoughts. Ultimately, he left every job. He also complained of difficulties in relation to his father; he said that his father did not understand him. He seemed to wish to be close with his father, but he had a great deal of difficulty achieving this. On one occasion he came to my office and told me that he had purchased a loaded revolver for his protection.

Please consider your course of action in John's case according to the two questions that I cited above.

Eric was a 20-year-old single male brought to me by his family upon his return from a year's trek around the country. Eric was a high school graduate who had developed some difficulties during his freshman year at college. He started using various illegal drugs such as marijuana and LSD, and he started having difficulties with his studies. At the same time his father, who was a career military man, was transferred from the city where Eric was attending college. This left Eric without any familial sources of support while he was attempting to negotiate his freshman year. Ultimately, he was unable to complete the second semester.

He continued to use illegal drugs with greater frequency as he attempted to deal with his upset emotions. When he left school at the end of the year, he hitch-hiked around the country finding various odd jobs and crashing with different people that he met along the way. In this erratic lifestyle, he was able to survive even though he was suffering a severe emotional disturbance. Ultimately, he found his way to the city where his parents were then residing, and he reestablished contact with them.

When he came to me it was obvious that he was suffering a psychotic thought disorder. I commenced outpatient services for Eric, using major tranquilizers to help combat his psychotic symptoms. Although the medication helped somewhat, Eric was quite troubled because he felt that he had done himself irreparable damage through the use of various hallucinogenic agents and that he would never be right again.

Because he did not wish to live at home with his parents, he lived with

several young men whom he'd known in the past. After several weeks in his new apartment, he called one night at about 12:30 a.m. and said that he had to see me. He was calling from a phone booth that was a short distance from my office. He arrived at my office 30 minutes later; he was quite upset. He told me that his housemates were plotting against him and planning to harm him. I asked him how he knew this. He said that he'd heard one of them mumbling under his breath, "We're going to get you." When I asked if he had any other evidence to support his concern, he said that he had none but that he knew they would harm him.

Is Eric dangerous to himself or others? Is involuntary hospitalization necessary?

The fourth case is Robert. Robert was a 46-year-old divorced, retired army colonel. He came from a family of career military officers, and his sister was married to an exceedingly high-ranking military officer at the time he came under my care. Robert was stationed in a foreign country in a consular position when his marriage went awry. In the midst of his marital problems, his functioning on duty had suffered, and he was ultimately relieved of his post and transferred back to the United States.

While the divorce proceedings were still pending and while he was functioning in a relatively low-level administrative position not commensurate in any way with his previous position, he made a very serious suicide attempt by slashing himself multiple times with a razor blade while sitting in a bathtub. By chance his sister arrived at his apartment while he was in the midst of the suicidal act, and his life was saved.

I was called into the case while Robert was an inpatient. He was suffering from a depression of psychotic proportions. I worked with Robert for approximately a year during which time his depression resolved, he retired from the military, and he set about establishing a new life. He went back to school in a year-long program to obtain a master's degree in foreign relations so that he could obtain a civil service job in a foreign country. This would have been commensurate with his previous military experience. Although he was able to do fairly well in school, he felt that he was not able to learn as much or as rapidly as he wished. He attributed this to his age and waning intellectual capacity.

Since things were going well in Robert's life, he decided to visit me on an every-other-week basis. During a week when I was not to see him, I was out of town at a meeting. I had left a message with my answering service that if anyone called, they could reach me at the hotel in the other city. During that week, Robert called my office and told my answering service that he was upset and that he had to talk with me immediately. The operator offered to give him the phone number or to try to reach me and have me call back. Then he hung up without leaving his phone number. My answering service called me at the meeting and told me of Robert's call. They asked me if I wanted them to do anything.

Please respond to this case according to the two hypothetical questions that I posed before.

As you may have guessed, the cases I have presented are actually true. Jane, the impulsive social worker, had a diagnosis of borderline schizophrenia. You will recall that she had acted violently in the recent past in relation to her father. As she stormed out of my office I experienced several feelings. One was fear for myself, for the other patients, and for my family. I have an office in my home, and it is not inconceivable that a violent patient could do harm to my wife and children. I followed Jane to her car, attempting to talk with her. She wouldn't listen. She jumped in her car and drove away in quite a rush. I was then faced with the decision of whether to institute involuntary hospitalization on a physician's emergency certificate, according to Connecticut law. I chose to refrain from taking that action until I'd had an opportunity to talk with Jane's parents who had an appointment to see me an hour later. We discussed what happened, and I told them of my concerns about the possibility that Jane might be violent to herself or someone else. We also discussed the possibility of hospitalization, either voluntary or involuntary. When her parents returned home, they found Jane in an exceedingly agitated state. They talked with her about the session that I'd just had with them and suggested that she take the medication that I had recommended. She agreed to do this. She calmed down and came back to see me the next day. Thus, I was able to avoid involuntary hospitalization.

In the case of John, the former Marine, I decided that although his having a loaded gun was an exceedingly dangerous situation, I didn't believe at that point in time his use of the weapon was imminent. Thus, I suggested to him that he return with his father for a joint session the following evening. Since I had seen John with his father in the past, this was not an extraordinary move. Once he was present with his father, I moved the discussion to John's feelings that he must protect himself. He ultimately told his father that he did have a gun in the car. By the end of the session, John had agreed to give the weapon to his father and to seek his father's help more actively when he was feeling as though he needed protection or wanted to talk with someone about it.

Eric, the hitchhiking drug abuser, seemed to me to be experiencing an exacerbation of his psychotic thought process when he came to my office in the middle of the night. At that point in time I entertained the thought that Eric might act violently towards his roommates were he to return to his apartment. I spent about an hour-and-a-half talking with him, trying to help him understand the reality of the situation. I also got him to accept a major increase in his medication at this point. I decided that it would not be appropriate to allow him to return to his apartment. With his agreement, I called his parents and made arrangements for him to stay with them for several days until things had cooled off.

Robert, the retired colonel, possessed an exceedingly high suicidal potential, for he was over the age of 40, he was divorced, he had few sources of emotional support in his life, and he had a history of another severe suicide attempt. When my answering service was able to reach me--several hours after he'd

placed the call to me--I decided that Robert was in severe straits and immediately called his sister and asked her to go to his home. I felt at that time that involuntary hospitalization was necessary in order to protect Robert from doing violence to himself. The tragic end of this story is that later in the evening I received a call from his sister saying that he'd been found dead in the bathtub. He had put a gun in his mouth and shot himself.

What is dangerousness? It is interesting that neither Dorland's Medical Dictionary,<sup>1</sup> Hinselwood and Campbell's Psychiatric Dictionary,<sup>2</sup> nor even the Psychiatric Glossary<sup>3</sup> of the American Psychiatric Association contain a definition of dangerousness. This finding suggests that "dangerous" is not a medical nor a psychiatric term, but rather a legal term. This happens to be precisely the case. Very few psychiatric authors attempt to define "dangerousness," although they do write about it from time to time. In a 1967 monograph, The Clinical Evaluation of Dangerousness of the Mentally Ill, Usdin says that dangerousness relates to aggressive and socially destructive acts.<sup>4</sup> In an excellent article entitled "Dangerousness and Psychiatry," Tananaki stated that a legal definition of dangerousness is a situation where "an act must occur in the community in the reasonably foreseeable future." This act, of course, must have a high probability of causing substantial injury."<sup>5</sup> He derives this legal definition from the findings of the United States Court of Appeals for the District of Columbia in Rosenfield v. Overholser<sup>6</sup> and Millard v. Harris.<sup>7</sup>

The problem for me as a psychiatrist is that it's impossible to say with virtual certainty that an act will occur or that such an act will be associated with substantial injury. However, a review of the legal and psychiatric literature about dangerousness indicates that such a prediction is just what the law wants when a psychiatric expert testifies concerning an individual's dangerousness. It appears that the law requires an exact accounting.

Unfortunately, however, dangerousness is a quality that we can only measure in degree. We cannot give an exact accounting. A person may be only slightly dangerous or they may be exceedingly dangerous. A finding of dangerousness is a subjective finding. Dangerousness is not an inherent quality of an individual. Dangerousness can only be ascertained in one individual in relation to another. Thus, a lion is only dangerous if it's standing beside me and is not separated from me by a series of iron bars. Similarly, Eric (in the case related above) had the potential for being dangerous to his roommates since he thought that his roommates were attempting to harm him. He was not dangerous in relation to me as he sat in my office that night. Alan Stone in the section "Dangerousness" in Mental Health and Law: A System in Transition, has said that "dangerousness, like beauty, is to some extent in the eye of the beholder."<sup>8</sup> Thus, dangerousness is a word which we use to describe a person who is potentially harmful from the frame of reference of the person who is doing the classifying.

The problem with the lack of consensus between law and psychiatry leads to the difficulties we encounter in utilizing the concept of dangerousness. The

court asks the psychiatrist to make a crystal ball prediction about the behavior of the particular individual in order to determine what legal course of action should be pursued. Dangerousness is usually at issue in relation to involuntary civil commitment and in relation to the insanity defense in criminal proceedings. In relation to both of these issues, a court goal is preventive detention. In my view preventive detention is valuable in the case of the mentally ill when there is substantial evidence that a person is likely to do harm to himself or others in the reasonably foreseeable future. In the case of an insanity defense for a crime already committed, there is good evidence of the dangerousness of the individual so that incarceration is in order to prevent him from harming or committing a similar dangerous act again in the future. In both these contexts, the court asks the psychiatrist to "guess" whether or not the person will behave in a dangerous fashion in the future. In the case where there is previous history of violent behavior, it is much easier to make such a prediction. With no history it is difficult if not impossible. In fact, Kozol and his associates in Crime and Delinquency state that "no one can predict dangerous behavior in a person with no history of dangerous acting out."<sup>9</sup>

A number of recent law review articles have dealt with the issue of whether or not psychiatrists can predict dangerousness with any degree of reliability or validity. A 1971 Arizona Law Review article on "Dangerousness and Committability" and the 1974 California Law Review article by Ennis and Litwack entitled "Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom"<sup>11</sup> are two notable examples. Both of these articles attempt to prove that psychiatrists are exceedingly poor predictors of dangerousness compared to laymen or to even actuarial devices such as experience tables.

Ennis and Litwack discuss the fact that psychiatrists tend to "overpredict" dangerousness; they are culturally biased; they don't have the proper orientation, training or experience to make these judgments; the entire diagnostic system in psychiatry is ambiguous and inadequate and so forth. This latter article in particular presents a number of misleading facts. For example, it is based for the most part on studies that were done at least 10 or more years ago and does not reflect the current state of the art. What is more, a number of the articles relating to inadequacies of psychiatric diagnosis are from the schizophrenic research literature, and they were written at a time when behavioral scientists were attempting to standardize their diagnoses so that they could do more reliable and valid research. Also, a number of their studies were done in state hospitals where attending staff was compared against psychiatric residents, who may have little experience and little command of the English language. The major fallacy of the Ennis and Litwack article is the assumption that a diagnosis of psychosis perforce means involuntary hospitalization will be instituted. Without going into more detail about this particular article, the authors were saying that there have been many abuses of involuntary commitment procedures based on psychiatric expert testimony concerning a patient's dangerousness. This point neither I nor

any other thoughtful person would dispute. However, their assertion that justice would be better served by flipping coins in the courtroom than calling in psychiatric expert testimony is a major distortion and unfortunately causes more damage than good in relation to the reframing of civil commitment statutes.

One basic problem concerning civil commitment is that the legal and psychiatric professions perceive civil commitment as serving different purposes. The legal view of the purpose of involuntary hospitalization is in order to prevent injuries such as suicide, homicide, or assaultive behavior. The prevailing psychiatric view is that involuntary hospitalization is for the purposes of treatment. Because the law says that involuntary hospitalization is to prevent harmful behavior, the law demands substantial proof that harmful behavior has in fact been prevented when someone is involuntarily hospitalized.

Based on developments in Donaldson v. O'Connor,<sup>12</sup> the law also says that hospitalization must not merely prevent harmful behavior; it must also provide treatment for the patient. The irony, then, is that where a statute cites dangerousness as a criteria for commitment, it uses not a diagnostic but a predictive label, perhaps better served by detention of nonmedical sort. Yet our society has evolved to the point where it specifically requires that treatment be offered in response to such a prediction of antisocial behavior.

The legal literature spends much time talking about the high number of false positive identifications of potentially dangerous people that occurs when psychiatrists attempt to predict dangerousness. A classic view of this type is from a 1974 Harvard Law Review article called "Civil Commitment of the Mentally Ill."<sup>13</sup> Citing Livermore, they demonstrate that if we had a 95 percent success rate in identifying potential killers and only a 1 percent false identification rate, and if 1 person of every 1,000 was a killer, and if we tested 100,000 people, then we would find 95 of the 100 killers in the population. However, we would also incorrectly identify 999 other people who are not killers but who by our tests are called killers. Thus, if we used this test to confine people, we would lock up 1,094 people to stop 95 killings and would still end up with 5 homicides. This type of reasoning suggests that we should not utilize the test of dangerousness as an indicator for involuntary hospitalization. As I will show later, I actually agree with this last premise, but not for the reasons stated.

Psychiatrists are trained to deal with clinical states. Dangerousness is not a clinically definable state. Rather, it is a word that can be used to define or to describe certain types of behavior. When I am treating a patient, I am mostly concerned with my ability to successfully help that patient. When I see a patient who manifests some type of potentially violent behavior, as did Jane in the case described above, I am obviously concerned about whether the patient will hit me--or one of the other patients if it's a group--whether the patient will return to do harm to my family or to my personal property or perhaps just drive off the road into a tree or a bridge abutment. In the case of Jane I was also concerned that she might turn her anger and hostility inward and thus

attempt to harm herself as punishment for her hostile and aggressive outbursts. I thought of hospitalizing her involuntarily to prevent this harmful behavior. However, I was most concerned about whether hospitalization would help in her treatment.

In relation to the issue of overpredicting, allow me to make the unqualified statement that as a psychiatrist I would far rather overpredict than underpredict. I realize that those of you that are civil libertarians are upset when I say this. You believe that I'm talking about a wholesale removal of civil rights from the unsuspecting masses. However, what I am saying is that when a patient is sitting in my office, I am wholly concerned with the welfare of that patient and of his family. If I make a wrong judgment about that patient's suicidal or homicidal intent, even when all the odds are in my favor, someone may end up dead. At the time of my earliest medical school surgical training, I was taught that if I did not take out some healthy appendices--either 20 or 30 percent depending on who the teacher was--I would most likely not be operating on appendices frequently enough. I would have patients dying of ruptured appendices. Similarly, as a psychiatrist, if I underpredict rather than overpredict suicidal or homicidal behavior, I am going to have patients either dying or killing other people. This is a difficult concept for the law to accept. If you personally are the victim of the patient, then the law of averages flies out the window. If I make a wrong call and you wind up dead, you are 100 percent dead no matter what the probability of the patient killing you was.

One legal misconception is that when a psychiatrist makes a diagnosis of a psychosis, this in and of itself is grounds for involuntary hospitalization. Nothing could be further from the truth. The Diagnostic and Statistical Manual of the American Psychiatric Association describes patients as psychotic when "their mental functioning is sufficiently impaired to interfere with their capacity to meet the ordinary demands of life."<sup>14</sup> This impairment may be accompanied by a number of bizarre symptoms of unusual behaviors. There is no particular psychiatric psychotic diagnosis that inherently connotes dangerousness. As a matter of fact, a number of different studies have shown that psychotic patients are less likely to have either suicidal or homicidal behavior than other individuals.<sup>15,16</sup> As an illustration of this point, of the four cases that I presented above, the first three patients had psychotic diagnoses. They did not do harm to themselves or others. Robert, the fourth patient, had a previous diagnosis of a psychotic depressive reaction. However, at the time that he killed himself there had been no evidence of a psychotic disorder for well over a year.

Although psychotic individuals do sometimes commit suicide and homicide, the proportion of those who do compared to the number of non-psychotic persons who commit these acts is small. One author has estimated that approximately 50,000 mentally ill people a year are predicted to be dangerous and are thus preventively detained.<sup>17</sup> As I said above, psychiatry in truth is not able to accurately predict the likelihood of a patient's future dangerous behavior, nor does



it claim it can. It is true that we as psychiatrists determine specific diagnoses for patients, and as we do this we are able to predict various behavioral likelihoods or tendencies. However, in no instance could this be construed as a specific prediction of some future event. It is this misunderstanding' on the part of the legal profession that has lead to the current disenchantment with psychiatric expertise. When I make a prediction that a patient is suicidal or homicidal and seek involuntary hospitalization for that patient, there is no way that I wish to have my prediction verified as to validity or reliability. To do so might well mean the loss of human life. However, when in the course of treatment I see the patient's state of mind improved, then I am quite satisfied with the veracity of my prediction and am obviously quite pleased with the result of my treatment.

Some writers suggest that perhaps dangerousness should not be a criterion for involuntary hospitalization. They find the operational definition of dangerousness that must be used in order to satisfy the court places psychiatry in the position of being unable to fulfill the demands of the court. One suggests that were the court to request the psychiatrist to predict whether a particular patient is homicidal or suicidal rather than dangerous in the broad sense of the definition, we would then have a task amenable to current psychiatric practice. Another goes a step further and suggests that since dangerousness in and of itself is not treatable, it does not make good sense to confine dangerous persons in treatment institutions. Rather, he suggests that preventive detention in criminal institutions--since we are attempting to prevent criminal acts--would be more appropriate.

I think it's fair to say that psychiatrists, in the clinical sense, find in dangerousness a concept that has very little usefulness. It is far more appropriate for psychiatrists to think in terms of psychiatric illness and its treatability or nontreatability than of the consequence of potentially violent behavior. which may occur in relation to specific psychiatric illness. Preventive detention in relation to these violent behaviors may be in order. However, psychiatrists believe that therapeutic detention is far more appropriate when possible. The question the court asks the psychiatrist should not be whether the patient will commit a violent act at some specific time in the future, but whether this disease process could best be treated through involuntary hospitalization. This is a question that we as psychiatrists could answer. Then you as lawyers would not have to spend so much time telling us how poor we are at making predictions of behavior.

#### QUESTIONS AND ANSWERS

QUESTION: Dr. Ruben, your talk was geared more towards the suicidal and homicidal tendencies. To your knowledge, does the concept of dangerousness go beyond the realm of physical injury? For example, would a person who is a compulsive check forger be considered dangerous?

DR. RUBEN: First of all, I think that's a legal question. I don't think the law has made such a classification. I don't think there's anything psychologically dangerous about a check forger, either. It could be the result of a psychological problem, but I don't think that in and of itself would be construed as dangerous.

MR. BRUTON: I think you've put your finger on one of the problems that Dr. Ruben mentioned. A patient can be a high social risk for committing an act such as forgery, but with our commitment statutes, there must be some danger of physical harm either to the patient or to others. This is a source of frustration to psychiatrists because if they commit someone and his only predictable risk is that he's going to write a cold check, then they're going to get hit with a habeas corpus or a false imprisonment action. It's a fine line they have to draw in applying the statute.

QUESTION: In scanning the occasional obituary columns of the AMA Journal, I not only see more deaths due to overdoses of drugs, but I also see more homicide deaths, sometimes defined as gunshot wounds to the chest and things like that. Comment please.

DR. RUBEN: I am sensitive to whether or not I am dealing with what I would consider a potentially dangerous person. But as I said in my talk, I think about that in terms of whether or not they may do harm to me, or, from what they've told me, whether they would do harm to themselves or to someone else. I know of instances where psychiatrists have been murdered by their patients, and so I am very concerned about that. And because I have an office in my home, I'm even concerned about my family's safety. The only thing I can say is that there are times when I become involved with the patient's delusional system. That's a very dangerous situation to the physician. The physician may be unable to deal with it in any appropriate way, including involuntary hospitalization, and the unfortunate result is occasionally death.

MR. PROSSER: If it's any consolation, lawyers quite often suffer the same demise. Mr. Barber would also like to respond to that question.

MR. BARBER: My comment is a little bit different, but I think when we put this panel together we wanted to have full integration. One of the fact situations that Dr. Ruben came up with--the one concerning Jane--plugs into a case out in California, Tarasoff v. Board of Regents. In that case there was a student who was under psychiatric care at the University of California at Berkley. He told a psychologist who in turn told a supervising psychiatrist that he was going to kill his girlfriend when she came back into town. The University officials notified the police authorities. This notification was subsequently countermanded by the psychiatrist, and ultimately this man did in fact kill this young lady. Suit was brought against the individuals involved and the University, and the Supreme Court of California ultimately decided that this action could be maintained on the theory that there was a duty to warn the girl and her family in this situation. I ask Dr. Ruben to comment upon that in light of the way that he handled Jane's case.

DR. RUBEN: As I understand the facts in Tarasoff, a psychologist saw the young man who ultimately committed the murder. It was the psychologist who notified the campus police, who then picked the guy up. If I remember correctly, they kept him overnight in the university health service. It was then that the supervising psychiatrist decided that the man was not dangerous. He had him released and also, for unknown reasons, had the record expunged. He actually removed the references in the record to the fact that the patient had said that he would perform a violent act against the young woman. I personally believe that, had I been in that situation, I would have notified the family. That doesn't necessarily mean I would immediately make a phone call, but I would definitely not just send a patient off and say, "I don't believe you." I would perhaps try to follow the patient and treat him. If the patient persisted with his stated intent, then I would think about involuntary hospitalization and most likely about warning the intended victim. In Jane's case, she didn't have a specific focus for her potentially violent behavior. She yelled and screamed at the patient in the group, she yelled and screamed at me, she'd already punched her father in the face, and in other family sessions, she'd been screaming at her mother. My wife was one of the attorneys who represented her for a short period of time, and when she fired her, she yelled and screamed at her, too. So she was focusing her anger on everyone, but on no one in particular. I was actually more concerned that she might attempt to commit suicide--that she would turn her anger inside. I did discuss it with her parents. We'd already had family sessions, so that I wasn't violating her confidence.

QUESTION: On Mr. Bruton's comment that dangerousness must be physical danger: as I read the law, your statement would be an interpretation of the law, but not how the law is specifically written. Would you comment on that?

MR. BRUTON: Granted, it's a statement of opinion. But courts sometimes like things drawn in black and white. The drawing is always done in the brilliant light of hindsight, and so this is probably the least subjective of the criteria that they focus on.

MR. BARBER: There's a brand new mental health law in the state of Kentucky. I'll read to you the definition of danger in the statute: Immediate danger or immediate threat of danger to self or others means substantial physical harm or immediate threat of substantial physical harm upon self or others, including actions which deprive self or others of basic needs of survival, etc. Substantial physical harm or substantial threat of physical harm, including actions which deprive self or others of basic means of survival, includes a provision for reasonable shelter, food, or clothing. But it does boil down to something physical, some act.

#### FOOTNOTES

- 1) Dorland's Illustrated Medical Dictionary, W.B. Saunders Co., Philadelphia, 1961.
- 2) Hinsie, L.E.; Campbell R.J., Psychiatric Dictionary, Oxford University Press, New York, 1970.
- 3) A Psychiatric Glossary, American Psychiatric Association, Washington, D.C. 1975.
- 4) Rappeport, J.R., ed., The Clinical Evaluation of the Dangerousness of the Mentally Ill, Charles C. Thomas, Springfield, Illinois, 1967, p.49.
- 5) Tanay, Emanuel, "Dangerousness and Psychiatry," Current Concepts in Psychiatry, Volume 1, #1, October 1975, p. 20.
- 6) Rosenfield vs. Overholser, 262 F.2d 34 (D.C. Cir. 1958).
- 7) Millard vs. Harris, 406 F.2d 964 (D.C. Cir. 1968).
- 8) Stone, A.A., Mental Health and Law: A System in Transition, National Institute of Mental Health, Rockville, Md., 1975, p.26.
- 9) Kozol, Boucher, Garofalo, "The Diagnosis and Treatment of Dangerousness," 18 Crime and Delinquency 371, (1972).
- 10) 13 Arizona Law Review 1 (1971).
- 11) 62 California Law Review 693 (1974).
- 12) Donaldson v. O'Connor, 493 F2d 507 (5th Cir 1974).
- 13) 87 Harvard Law Review 1190 (1974).
- 14) Diagnostic and Statistical Manual of Mental Disorders-11, American Psychiatric Association, Washington, D.C., 1968.
- 15) Gulevich and Bourne, "Mental Illness and Violence," in Daniels et al., Violence and the Struggle for Existence, Little Brown, Boston, 1970, p. 390.
- 16) Schuckiet, M., Gunderson, E., "Suicide in the Naval Service," 134 American Journal of Psychiatry 1328-1331, 1975.
- 17) Rubin, B., " Prediction of Dangerousness in Mentally Ill Criminals," Archives of General Psychiatry, 27: 397-407, 1972.

## CIVIL COMMITMENT OF THE MENTALLY ILL PATIENT

William D. Weitzel, M.D.  
Assistant Professor of Psychiatry  
College of Medicine  
Lexington, Kentucky

This morning I'd like to review how civil commitment of mentally ill patients to hospitals evolved in our country. Then I'd like to talk about the current state of things and about developing legal decisions and guidelines which I think are going to have a profound impact. I'd like to conclude with some of Dr. Alan Stone's ideas on this topic which are different from the way things have been and are being done now.

The history of American psychiatry and law document a struggle between two major themes. One involves society's expectations of protection against arbitrary and unconstitutional restrictions of freedom of behavior. A tension, it seems to me, must exist inevitably between society's need and individual rights. Civil commitment of the mentally ill patient involves real life dilemmas in which we must balance both desirable goals.

During our nation's colonial period the only laws concerning violent and dangerously insane people dealt with detention under authority of the sovereign's police power: those considered dangerous to others were simply arrested. A Massachusetts statute of 1696 ordered the selectmen of towns with "dangerously distracted persons" to take care of them that "they do not damnify others." Not until the 1780's, however, did various states enact legislation which explicitly provided for the lawful confinement of those who suffered from lunacy or were otherwise so furiously mad as to be harmful to others. No specific laws concerning commitment procedure which provided legislative safeguards protecting personal liberty and patients' civil rights were enacted until the middle of the 19th century.

Prior to the American Civil War, or during the era of what we call moral treatment, commitment of patients to hospitals under statutory authority was effected quite easily and often merely on the request of a friend or a relative. Commitment could even take the form of a hastily scribbled few words on a scrap of paper signed by a member of the hospital staff.

In 1845 a new idea was introduced to this process. In that year Josiah Oaks petitioned the Massachusetts Supreme Court to release him from confinement, claiming that his family had committed him to an asylum without justification. The Chief Justice of the Massachusetts Supreme Court denied this request and endorsed the idea that the confinement of a mentally ill patient continue as long as it is required for the patient's own safety or for that of others and that this is the proper limitation. This decision is reputed to have established the foundation for justifying and limiting the extent of confinement of mentally ill patients. It was probably the first time that a therapeutic justification for confinement was decided in a court in this country. A discernable trend now began toward broadening the reasons for commitment of the mentally ill patient to include

therapeutic reasons.

The evolution of involuntary commitment legislation in the United States changed further in the 1860's. A woman by the name of Mrs. E. P. Packard was committed for a period of about 3 years to a state mental institution in Illinois after differing publicly on a religious issue with her husband who happened to be a preacher. The preacher won the argument by having her committed. The Illinois statute provided that a married woman could be committed on the petition of her husband "without even the evidence of insanity or distraction required in other cases." At the time of her discharge in 1863 she claimed that she had been victimized by her husband and was quite sane when committed. She launched a nationwide campaign after her release for the enactment of protective legislation to benefit the insane. Her successful campaign resulted in changes of civil commitment laws to include such important safeguards already present in criminal law such as notice to the patient that a petition has been filed for commitment, a fair hearing on the issue, and finally the right to a jury trial.

There were no provisions in the United States for voluntary hospitalization to public mental institutions until the end of the 19th century. Some of the earlier laws limited voluntary admission patients to only those who could pay. After emphasis on early diagnosis and treatment of mental illness gained momentum in this century, states began to alter their policies and allow voluntary admissions.

The National Advisory Mental Health Council in 1949 requested the Council of State Governments and the United States Public Health Service to develop what might be considered a model act with guidelines and suggestions for preventing the obvious indignities and humiliations which psychiatric patients were still experiencing. The recommendations in this document were transmitted to all state governors and used to help modify legislation in many states in this country during the next two decades.

In 1959 the British Mental Health Act was passed with the stated intent of protecting psychiatrically ill patients from humiliating publicity and deprivation of their rights and opening easier access to treatment. According to this Act, an insane person may be hospitalized for an indefinite period on the recommendation of two private physicians without procedures of a hearing by a court or an administrative tribunal. In addition, the act authorizes compulsory hospitalization of patients afflicted with mental illness, mental subnormality, and a variety of psychopathic disorders. However, these concepts are not clearly defined.

Some authors feel this legislation is a step backward in terms of effective protection against indiscriminate detention and involuntary commitment of the mentally ill. It is consistent, however, with the trend in recent years toward emphasizing the justification of commitment of the mentally ill on the basis of therapeutic reasons. Unfortunately, therapeutic good intentions have not always squared with reality. In 1961 the Joint Commission on Mental Illness and Mental Health published a report in which it was alleged that over 80 percent of the

state hospitals in the United States at that time offered no treatment whatsoever to patients confined in them. Statistics compiled by the World Health Organization indicate that only 10 percent of the psychiatric hospitals in 1955 were on a voluntary basis.

The enormity of the problem can be appreciated when it is remembered that it is estimated that one person out of ten in this country will be hospitalized at one time or another for treatment of a mental disorder. In 1973 one half of the hospital beds in the United States were occupied by mental patients. Over 308,000 resident patients were in the country's 321 state and county mental hospitals and one third more were in private hospitals and in the psychiatric wings of general hospitals. In addition, approximately 260,000 of the more than 6 million mental retardates in the country are now in mental institutions.

The morality of involuntary hospitalization is now being vigorously challenged. Outright repeal of all laws of civil commitment is urged by the American Association for the Abolition of Involuntary Mental Hospitalization which was organized in 1970, and a lot of the leadership in this organization has come from another familiar figure in American psychiatry, Dr. Thomas Szasz. The group urges members to "oppose currently accepted psychiatric and psychological practices that rest on the use of state supported force and fraud."

A current report suggests that the number of involuntary civil commitments is declining. As of 1972 it appears that the pendulum has swung such that voluntary admissions to psychiatric facilities now outnumber involuntary ones. However, data also suggests that two out of every five persons admitted to state and county mental hospitals during 1972 were there against their wishes. It's difficult to know how many of them chose to enter voluntarily only because of threat of commitment.

Let's talk now about the choices of admission that an identified mental patient has. In the 20th century a patient can request an informal voluntary admission to a mental hospital. This is with a minimum of formality and the patient retains the right to depart the hospital when he chooses. Three separate grounds for involuntary civil commitment are usually allowed. These vary from state to state but are usually found when the patient presents danger to others, danger to himself, and now in Kentucky when his actions would lead to the deprivation of the basic means of survival. The first is based on a threat to society and the latter two on the concept of parens patriae. The threat to society is clearly a strong justification. The right of the state to confine persons dangerous to themselves rests on different grounds. In spite of John Stuart Mill's maxim from his 1859 essay on liberty, the state has frequently intervened with the mentally ill who are considered dangerous to themselves. Mill wrote, you remember, that the only purpose for which power can be rightfully exercised over any member of a civilized community against his will is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.

There are at least three types of involuntary commitment or compulsory

admission. Commitment is defined here as the legal process whereby at the request of a relative or a friend two doctors explain to a court why it is necessary to deprive a patient of his freedom. An emergency commitment usually uses a simplified form and is the most often used means of effectively getting a patient into the hospital with a minimum of delay. This forced hospitalization remains valid only for a limited duration. Until June 18 in this state it is 48 hours. After June 18 it is 72 hours. An American Bar Foundation report notes that emergency care commitment is not technically a hospitalization but rather a form of detention. During the period under which an emergency hospitalization commitment is in effect, family or friend must petition for a formal judicial commitment and two physicians must vouch that it is appropriate as defined by the law. This process can be avoided if the patient signs a voluntary admission form during the course of the emergency commitment.

Under a formal judicial commitment a patient may be hospitalized either for a prescribed period or for an indeterminate period. Until June 18 in this state, it is indeterminate. After June 18 it's 60 days or 360 days. So he can be hospitalized for a prescribed period without his consent and over his objection based on the certificates of two physicians.

A third type of commitment involves observation. This procedure is designed only to help formulate a diagnosis or determine whether long term commitment is required. Such a procedure can be used with people who are arrested by police and accused of a crime, a vicious sex crime, for example. This kind of an individual can be sent to a state hospital--in this state the forensic unit--for a period of observation with a report subsequently being sent to the court.

The following comments are an overview; not all apply specifically to this state.

In a survey of approximately 2,500 commitment proceedings, fewer than 1 percent were found to be formally contested. The chief reasons for the "no contest" is that the patient's psychotic condition makes an organized effort to defend himself impossible. In addition, the physician will seldom press for commitment in the face of opposition from the family unless the patient is clearly homicidal or suicidal.

I'd like to review for you now the following groups which have been or currently still are committable. First of all is the mentally ill person. This individual is defined variously as a person who is suffering from an illness which so lessens his capacity to use his customary self-control, judgement, discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under care and supervision, guidance and control. The second group is made up of mental defectives, otherwise called mentally-retarded persons, mentally-handicapped persons, or feeble-minded persons. We also have a new law in this state with respect to these people which takes effect in July. This group is now covered, as I mentioned, under special legislation and not under the usual commitment legislation. It was interesting to me



that when our legislature acted on this, their coverage was proposed in two separate bills with two separate numbers but were dealt with in committee and in the voting as if they were one package.

Another group is made up of epileptic persons. These individuals are described in various state mental health laws as "persons suffering from any condition which brings about lapses of consciousness which may or may not be accompanied by convulsive seizures which may become chronic." The epileptic so uncontrolled as to be dangerous is subject to commitment. The following remark is from Dr. Slovenko's book, Psychiatry and Law. Dr. Slovenko claims that according to epilepsy agencies in this country only 20 percent of the known epileptics in the United States are receiving adequate treatment.

Inebriated persons are defined in various mental health laws as persons who are habitually so addicted to the use of alcohol or other intoxicating or narcotic substances as to be unwilling or unable without help to stop the excessive use of such substances. Judicial commitment is usually resorted to only in cases in which the patient is psychotic and needs confinement for treatment of this phase of his illness.

The so-called sexual psychopath is described as a mentally ill person under the broad legal definition of some mental health laws and has been committable in some jurisdictions. These laws are increasingly challenged and usually are found unconstitutional.

The aged are committed with greater frequency to public mental hospitals. They comprise approximately--according to Slovenko--40 percent of many psychiatric hospital populations even though not psychotic.

Probate court has full jurisdiction over neglected or delinquent juveniles under the age of 17, usually. If a juvenile is committed, the court retains custody over him while he is in the institution.

It seems to me the principal abuse in commitment procedures occurs not at the time of the initial commitment but rather subsequently when the patient could be allowed greater freedom or placed in a halfway house or a foster care home. Such facilities are rarely available or have limited capabilities. Therefore, the writ of habeas corpus becomes an important tool. The writ, as you know, has for its object speedy release by judicial decree. It may be obtained on the behalf of anyone who claims he is being restrained of his liberty illegally. Since involuntary commitment may continue only as long as the patient needs care and custody, he may at any time petition for the issuance of such a writ on the grounds that he is now sane and entitled to release.

I'd like to talk to you now about some procedural developments. In 1972 a lower federal court while reviewing the Wisconsin commitment laws held for the first time that--imagine now, we're talking about a patient, that's what bothers me about this--in addition to requiring notice, hearing and right to counsel, the United States Constitution mandated three other procedural protections for persons protecting involuntary commitment: (1) beyond a reasonable doubt standard of

proof, (2) a Miranda warning to enforce fifth amendment rights against self-incrimination, and (3) a principle favoring the least restrictive alternative with the burden on proponents of hospitalization to prove that necessity. This case, Lessard v. Schmidt, 379 F. Supp. 1376 (E.D. Wisc. 1974); vacated 421 U.S. 957 (1975), was vacated on a technicality by the United States Supreme Court but is now back again for further consideration. Beyond a reasonable doubt certainty is something like 90 percent certainty. The District of Columbia Court of Appeals has recently held in a 1973 case that beyond a reasonable doubt standards must apply in commitment cases in that jurisdiction.

In Bell v. County General Hospital at Eloise 384 F. Supp. 1085 (E.D. Mich. 1974), a three judge federal court struck down the Michigan temporary commitment law as unconstitutional. These findings are similar to those in the Lessard case and I'd like to list them for you. In order to be constitutional the Michigan court required the following changes: the law must provide for service of the commitment petition itself on the respondent himself sufficiently in advance to permit him to evaluate the allegations and prepare his response. The respondent must be notified that he has a right to legal counsel. The statute may not provide for a prehearing determination that the respondent's condition is such that he ought not to be present at the commitment hearing. The statute must provide for notice to the respondent that he has a right to a jury trial, and a balance has to be struck between dangerousness to self or others and the patient's amenability to treatment as against the curtailment of liberty that commitment represents. The law may not permit involuntary detention without a hearing for more than a short period, probably for 5 days. The statute may not permit a voluntary treatment of a "physically intrusive nature" prior to a final adjudication of mental illness except when the patient is presently dangerous to himself or others and provided such treatment is necessary to maintain physical health.

You remember when I talked about admissions procedures I mentioned that the emergency commitment is by far the most common legal vehicle for involuntary confinement and most often utilized in the management of psychiatric crises. The overwhelming majority of our patients within the short period of time--48 to 72 hours--realize the wisdom of becoming a voluntary patient and accept treatment. You understand, though, that what I just read was an attack on that approach in Michigan. So it seems to me that these procedural requirements in Lessard v. Schmidt and Bell v. Wayne County created a serious practical impediment to the effective management of psychiatric emergencies. Of course, we don't know how this is going to end up. All these cases remain unresolved in any final way.

I'd like to talk to you now about the Lanterman-Petris-Short Law, (LPS), the 1969 California law which made the criteria for involuntary commitment more stringent and increased the legal rights of committed patients. LPS was the result of legislative distrust of the decision-making process in commitment. The major provisions of the LPS law are as follows. A person may be detained 72 hours on the request of any private person or police officer and a written application by

a mental health professional--whatever that is--designated by the county following a preliminary screening of the patient. The staff of the psychiatric facility may then certify the person for an additional 14 days of treatment and observation. After 17 days any further confinement requires judicial review. If the court believes the person is suicidal, he can be held for 14 more days and then he must be released. If the courts find the person immediately dangerous to others, another 90 days of confinement is allowed and if gravely disabled, a conservatorship is granted the person detained and his status is periodically reviewed.

It was anticipated that the flow of mental patients to in-patient facilities would be diminished since LPS made screening mandatory and screeners would, of course, refer all those suitable to alternatives in out-patient facilities. In fact, though, the most important changes have been in the decreased duration mandated by law and the locus of hospitalization rather than in the number of people hospitalized. The quality of care has not been demonstrated to have improved. While some who would formerly have been committed are undergoing out-patient care, a much greater number have refused referral and found their way into the criminal justice system. This resort to criminal processes confirms again what I think I see again and again, a widely known phenomenon that the penal and mental health system operate presently in an overlapping and reciprocal way for the control of deviants.

I'd like to go on now to some of Dr. Stone's ideas. We've reviewed how we got here, what's going on, and what may be coming in terms of further legal guidelines.

Research reports and clinical experience to my mind have produced a growing and renewed confidence in traditional diagnostic nomenclature in psychiatry, particularly in terms of psychoses. The development derives in part from a variety of biological and genetic studies as well as the accepted effectiveness of psychotropic drugs and other somatic treatments that seem to confirm aspects of the medical model. As I mentioned, Allen Stone, who is a professor of psychiatry and law at Harvard, has suggested that the reliability of psychiatric diagnosis could be improved if for the purpose of civil commitment, psychiatrists would confine themselves to broad diagnostic categories and in addition only diagnose severe conditions. A review of the literature confirms this hypothesis and reveals that the more severe the illness the greater the diagnostic agreement. Stone proposes a five step procedure which he refers to as the "thank you" theory of commitment. The five steps are : (1) reliable diagnosis of a severe mental illness must be made, (2) an opinion must be rendered that the person's immediate prognosis involves major distress, (3) a conclusion must be reached that the appropriate treatment is available, (4) an opinion must be made as to whether the diagnosed mental illness impairs the person's ability to accept treatment, and (5) an opinion must be made as to whether a reasonable man would reject the treatment recommended. All these questions could be addressed at a hearing with counsel within a few days of confinement. What the psychiatrist does in this system is

first make his diagnosis. If it cannot readily be demonstrated that this is a reliable diagnosis of a severe condition, the process would go no further. The reliability and severity could be challenged or demonstrated by independent psychiatric examination.

The "thank you" theory of civil commitment asks the psychiatrist to focus his inquiry on illness and treatment and asks the legal profession to guarantee the treatment before it intervenes in the name of parens patriae. This proposal is radical in the sense that it insists that society fulfill its promise of benefit when it infringes on human freedom. Civil commitment is divested of a police function. Only someone who is irrational, treatable, and incidentally dangerous would be confined in a mental system. Developing Professional Standards Review Organizations should now be able to provide courts with base line perspectives with respect to treatment standards for specific diseases. Expectations among all participants in this process will be clear.

It is well known that where mental services have been upgraded and psychiatrists have become sensitive to legal issues, involuntary commitment can and has become a more infrequent event. In communities in which improvement treatment opportunities do not exist, the result is battles over legal standards and procedures for admission. The end result of such activity many times is the freedom of mentally ill patients to suffer their illnesses outside an institution without access to effective medical care.

I'd like to conclude my remarks with an observation. I have read a lot in preparing this paper and I have reviewed a lot of Dr. Stone's work--and if there's a spokesman on this issue in American psychiatry today, it's probably he. He reflects a growing pessimism when he speaks as a psychiatrist to other psychiatrists that the hour is very late and that things may have gone too far in terms of all the laws, restrictions and regulations that have been written and imposed. Of course, what you see happening in this community and nationwide is that there are indeed fewer civil commitments. This has aroused fervor in some authors who have written such impassioned papers as "Dying with your Rights On" and have reported several cases of people who have been allowed to kill themselves or be killed or kill someone else while free.

I wonder sometimes, how much good we do when we write all these rules and restrictions. I'd just like to make the observation that for a very seriously depressed person, who especially hasn't responded to anti-depressants, ECT really works. And you know, there's a state hospital in the neighborhood here where they haven't used that procedure in 2 years. Now it's too much for me to believe that they don't have sick patients that need it. I asked about that and what happened is that the guidelines are so cumbersome and so strict that it doesn't happen.

#### QUESTIONS AND ANSWERS

MR. BARBER: Dr. Weitzel has a comment on the seeming continuation of a trend with respect to commitment procedures. Mental retardates, as usual, are lumped in with

people with mental disorders. Retardation is by definition a noncurable condition. As far as I'm concerned I see no rationale for using one as a precedent to the other in involuntary commitment procedures. Perhaps you do.

DR. WEITZEL: No, I would agree with you. I don't disagree with you.

QUESTION: This goes on with the controversy. I'll give you the case of a 47-year-old man, a white-collar worker, modest income of \$15,000 a year, a very stable family man who at the age of 47 had his second episode of manic illness. In this illness he developed the idea that it was his duty to influence legislation in various parts of the country. To do this he began to fly hither and yon in a rather wild, impassioned manner. He exhausted the family savings, he took a second mortgage on the house, immediately when getting his paycheck he used it to buy airline fares and he was discharged from his job after this had gone on for approximately 6 weeks. The family then became practically destitute. In the interim of the 6 weeks the wife, recognized that her husband, who had previously been quite stable and reliable, was mentally ill. If we stick to this idea of physical dangerousness the psychiatrist has a very easy task; he simply throws up his hands and says, "Don't talk to me, there's nothing I can do about it." That's a very easy way to practice psychiatry, but in my opinion it is not a very responsible way if one is interested in treating the mentally ill.

MR. PROSSER: We just has a consensus on this side of the table. What you do then is you go to a conservatorship by going to probate court and having a committee or guardian appointed to handle all this man's money so he can't buy an airline ticket. I don't know how you gentlemen feel, but I think the legal side would say you can't commit this man because he's not dangerous. Would you agree gentlemen?

DR. RUBEN: My opinion is that it obviously depends on the jurisdiction. In Connecticut they have just reframed the commitment statutes to include imminently dangerous in the physical sense or gravely disabled, and therefore, I would institute the 16 day emergency certificate and put him in the hospital during which time he could perhaps get treatment started. Obviously a manic state is very treatable. We might be able to get him under control and then into out-patient treatment and never have to go into a conservator proceeding although perhaps he would have to go for a longer term commitment if his manic illness was intractable.

MR. PROSSER: Let us realize something about commitment and safeguards. These safeguards are there to protect the innocent just as the criminal law safeguards are there to protect the innocent. Everyone in this audience is fully aware of the abuses which are inherent in our commitment proceedings. We have someone we don't want hanging around so we commit him. If he were rich, he'd be eccentric, but he's not. We're uncomfortable, so we commit him. We don't want Uncle Harry spending our inheritance which we're going to get when Uncle Harry dies so we commit him. These are the reasons we fight so hard for these constitutional safeguards. Quite often it appears as though the legal profession is at logger-

heads with the medical profession. But if you think behind the reasons for our fight, I think you can accept the reasons why we are fighting. Another question? QUESTION: I would like to know how often you really see that happen. Does that really happen? Is that your data? Have there been studies? I'm talking about the 1970's.

MR. PROSSER: All right. I'm going to ask either Mr. Barber or Mr. Bruton because my field is mental retardation not mental illness. I can't respond. Do you gentlemen want to say anything about that?

MR. BARBER: Well my field is mental retardation, too, but I suggest that it might come not in the form of fighting to keep a patient out but suing the doctor that put him in there. There's a lot of law being made in that direction.

MR. BRUTON: At the risk of blowing a good portion of my speech, I think it's fair to say that since the first of October of last year I've had nine different individuals come into my legal office in Louisville with stories of having their rights violated in treatment in mental institutions, both private and public. Of the nine people, and I checked out the story, six of them had really substantial deprivation of rights by the standards that I'm going to talk to you about today. That's just my personal knowledge within the last 9 months.

MR. PROSSER: The situation is this. In Fayette County, in Jefferson County, in our major population centers, we may not have the problem as seriously as it is in these rural counties where if the power structure doesn't want someone in their county or their community and they cannot find a criminal charge to bring against him, they'll say this guy's loony and ship him off to Eastern State Hospital. Eastern State will say there's nothing wrong with this man and send him back, but he is still taken out of the community and his constitutional rights have been violated. We cannot judge Kentucky by Lexington. It happens all the time.

QUESTION: I can give you a more precise illustration than that. I represented a lady who had filed a suit for divorce against her husband in eastern Kentucky. He had her committed.

MR. PROSSER: So you see it still happens. The 19th century is still with us in a lot of areas.

QUESTION: Let's hear the rest of this case. Did the physicians at the hospital to which this person was committed then conspire in this criminal way with the husband or did they behave as responsible people and release the patient when it was adjudged that she did not need to be there?

MR. PROSSER: Do you feel you would have a cause of action against the doctor who conspired in this commitment?

QUESTION: No, No.

MR. PROSSER: How did the husband proceed in this commitment proceeding?

QUESTION: He went to the county court and got statements from two doctors which was the proceeding under our statutes. So he proceeded legitimately under the statutes but the room for abuse was there.

MR. PROSSER: All right, the lady was incarcerated for a week; in effect she was in jail for a week although the jail was labeled hospital. That's the thing we're talking about, fighting these abuses. Is there another question?

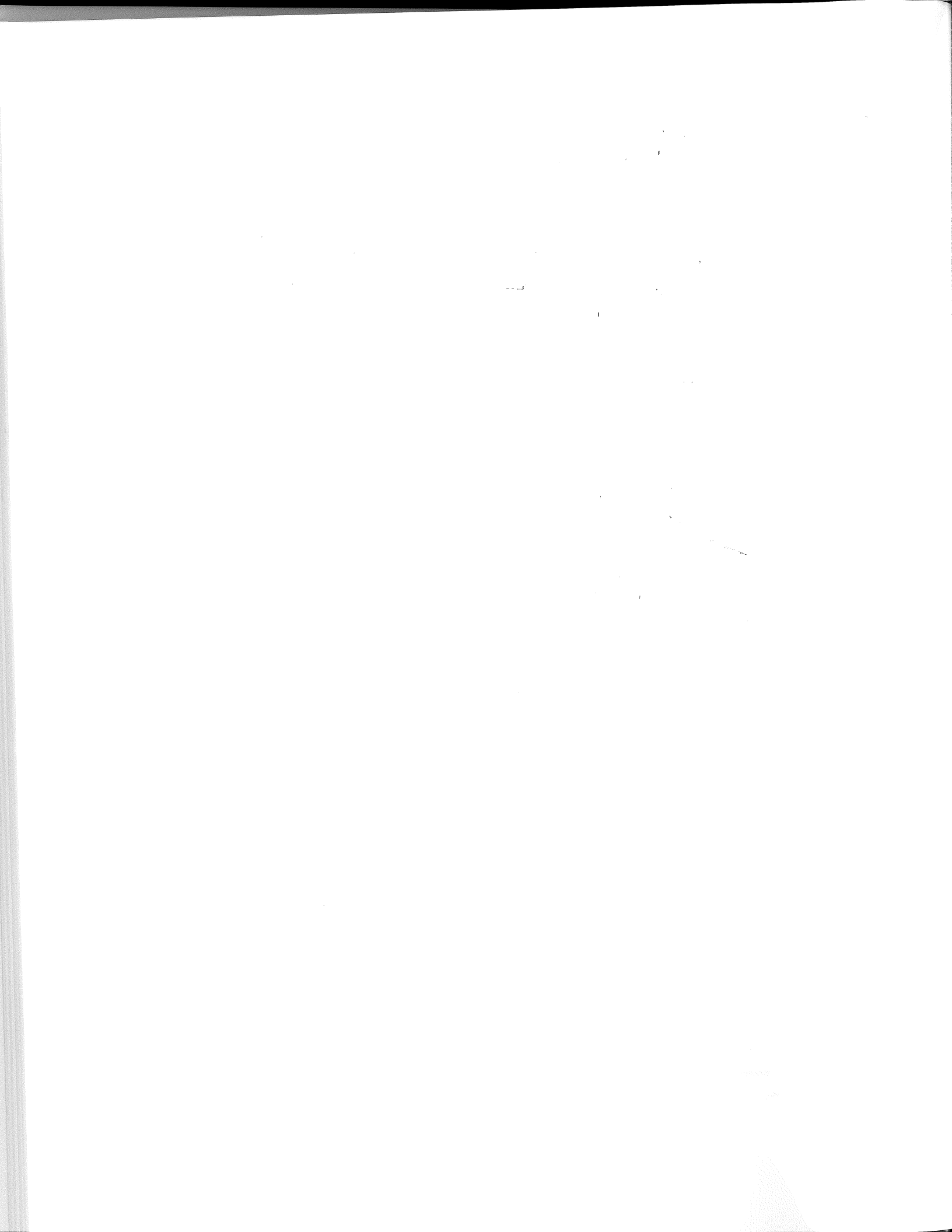
QUESTION: There were two references to physical evidence. I wonder if we might have a definition?

MR. BARBER: When this mental health statute was written there was a lot of reference in this state as to the other case law. In correspondence with the Attorney General from the state of Missouri and also the attorneys that are involved in the Lessard case up in Wisconsin the feeling was generated that you would have to have some type of overt threat or some type of overt action on the part of the individual before the doctor would be able to say substantial threat of immediate danger to self or others as is defined under the statute. The courts are not too specific on exactly what would constitute an overt threat or what fact situation would constitute an overt threat or exactly what type of physical activity would have to take place. In order to help explore this problem, before the mental health law was adopted here in Kentucky in April of this year, there was a national conference on mental health law focusing on dangerousness and incompetency. We brought in experts for 450 people to listen in the southern part on Indiana right across the bridge from Kentucky. We tried to get some type of working definition of what type of act and what type of statements would implement this type of statute. We simply weren't able to do it. The experts that we brought in at that time--including the man that's the head of the center for behavioral studies of violence at the University of California at Los Angeles--basically indicated that you have to go on a case by case basis. I believe that's what's being done in the major hospitals in Kentucky at this time. I really feel totally incompetent on giving you specific facts or specific statements that would have to be made by an individual before you trigger the statute.

MR. PROSSER: Mr. Barber has admitted incompetence but he's not dangerous. We can't commit him this morning. One more question then we'll go on to the next speaker.

QUESTION: Doesn't the decision or opinion on the part of the doctors to commit a person depend upon the philosophical outlook of the doctor on the subject. For example, you have a close case of dangerousness and one psychiatrist will say "Yes, that person should be committed" and another psychiatrist will say no. Doesn't it depend on the philosophical outlook in many instances of the doctor?

DR. WEITZEL: I'd like to make two points in response to that. One, I'm amazed at how many of my colleagues are unaware of the details of the commitment law under which we operate. I think some of us are uninformed when we react to a crisis situation. Two, I think Dr. Ruben has already stated that we as a profession tend to be overly cautious and when in doubt do what we would consider the safest thing. We'll find out later this morning if we'd be more culpable for allowing someone whom we thought was likely to commit suicide and whose family brought him in for an evaluation to be committed than we could be if we didn't act.





## MALPRACTICE HAZARDS IN PSYCHIATRY

Oliver Grant Bruton Jr., J.D.  
Middleton, Reutlinger and Baird  
Louisville, Kentucky

There was a time when psychiatrists and psychologists appeared to be avoiding the malpractice claim explosion and were high up on the most favored list of medical malpractice insured. Various reasons were given for this. My private hunch is that there is a very real correlation between doctor-patient contact and the willingness of patients to file suit. It's no coincidence that the highest risk category of medical malpractice defendants are those super specialists who have very little contact with the patient; anesthesiologists, neurosurgeons, and so forth. Almost by definition psychologists and psychiatrists establish personal contact with their patients. In spite of this, these practitioners are now finding themselves in court with greater frequency. A study of published cases involving psychiatrists was made, and we can see how the trend is growing. From 1931 to 1940 three of such cases were found. From 1941 to 1950, seven. From 1951 to 1961, nine were found. From 1961 to 1970, 25 were found. And I would bet that the number of cases will increase in the same proportion in the decade of the '70's. Again, this increase is not surprising when one considers that about half of the hospital beds in the entire county are occupied by mental patients. One article I read established the number to be at about 750,000, but I couldn't determine the source of those figures although I gather Dr. Weitzel can confirm that 50 percent figure.

Compared to the many, many cases involving other types of physicians, published cases involving psychiatrists are few and far between. The best collection I've found so far is 99 A.L.R.2d 599. The title of the annotation is "Malpractice Liability with respect to Diagnosis and Treatment of Mental Disease."

I suppose every physician or practitioner will become voluble on the subject of why his specialty is so vulnerable to attack by lawyers. Psychiatrists are no different. They complain that the legal profession constantly requires them to steer between Scylla and Charybdis. For example, there are several cases which hold, particularly with respect to voluntary suicidal patients, that failure to restrain them may be malpractice. Yet there are other cases which hold that improper confinement or supervision can be characterized as battery or false imprisonment. Because of this, reams have been written in psychiatric journals about the benefits to be obtained from an open door policy of returning the patient to the community. Yet when this is done and the patient injures himself or injures someone else here come the summonses.

Every physician and most lawyers are aware of the importance of the informed consent of the patient before a course of treatment is begun. Yet in many instances the psychiatrist's patient is incapable of giving informed consent, and there's no time in emergency situations to go through commitment procedures whereby someone else can give a legally binding consent. As we've seen up to

now even the commitment procedures themselves are traps for the psychiatrist. Keep in mind that all these malpractice cases arise and are tried in the brilliant light of hindsight. If, for example, a patient contends that he was falsely imprisoned and wants money for it, he can put on an awfully good appearance, convince a jury or a judge that he's very meek and mild, and they can really wonder how the doctor concluded that he was dangerous. I submit to you, these recent cases we've just discussed to the contrary notwithstanding, that there can be no beyond reasonable doubt criteria with respect to diagnosis of whether a patient is confinable or dangerous, whatever that means.

In my view some of the reasons for the confused body of law that relates to psychiatrists and psychologists is illustrated by the title of this talk, "Malpractice Hazards in Psychiatry." The implication from the word malpractice is professional negligence. This is something we lawyers know something about. Normally, the precedents, the analogies, and so forth are made by other physicians who fail to abide by a standard of care. Unfortunately the psychiatrists, and the psychologist's exposure goes way beyond negligence. Witness all these false imprisonment cases, the cases for defamation, the cases for battery.

Of course, there are also many cases that fit within the classic malpractice pattern, but I submit to you, that they'll be falling off in the future. These are the electroshock therapy cases, the insulin shock cases, and wet pack treatment. Electroshock therapy involves a real risk of violent muscular reaction. Bones get broken, people die. Insulin shock cases and wet pack treatment cases are similar. But in these type of cases we can and do have the usual expert testimony relating to standards of care. I hope these claims will be falling off, because I hope with the discovery of new drugs that these types of therapy will be used less and less often and, to express a layman's predilection, I hope they will go the way of frontal lobotomy.

Most of the cases that are tried are the ones that result from injuries caused by mental patients either to themselves or to others. The usual allegation is that the physician is negligent in failing to supervise treatment or to restrain the patient. It's in this type of case that the psychiatrist is heard to wail "What do you want from me?" It may be determined that it would be a good thing to keep a depressed patient in a closed ward, or it might not be good for him. So they put him in an open ward, and he jumps out the window. It isn't hard to create a jury issue on the subject, and if you have a jury issue, you will have laymen hearing conflicting theories of treatment. If you have a serious injury, you will have a possibility of a substantial jury verdict.

Medical malpractice lawyers have noted the weakening of the so-called locality rule. The time was when, for the benefit of the practitioners in the boondocks, the courts held that a physician would be held to the standard of care for his community and not necessarily the more sophisticated standards of care in the country. The locality rule is now in disrepute and that protection for the under-informed physician is falling away. However, more often than not a psychiatrist will want to invoke standards of practice that developed in other communities as a rationale for treatment that is unfamiliar to the community. Everyone knows

psychiatrists shuffle themselves around the country quite a bit. Mr. Barber and I, for example, are taking opposite sides in a case where therapy for drug addicts developed in communities other than Louisville is an issue. You'd better believe, Mr. Barber, that we will invoke national standards of care in our proof.

In addition, there are other precedents which I contend are misapplied in the realm of psychiatric malpractice. All of us know that with a little application and a little discovery we can make a jury issue out of failure to warn. But what is a psychiatrist supposed to do? Does he tattoo a warning on the patient's head?

Keep in mind that because of the unjustified stigma which is attached to mental illness, psychiatrists are getting exposed to claims that other specialists don't worry about too much. One psychiatrist--to give you another example--failed to note when he was writing a report about a patient that the patient was a junior. A patient with a similar name but who wasn't a junior, sued him for defamation. In another case the doctor wrote what was alleged in a lawsuit to be a derogatory letter about a patient's condition. It was used by a hostile spouse. The doctor got hit with a libel suit.

The most tears are shed by psychoanalysts who think they are doing the right thing and then are told by a court that they are not. In Hammer v. Rosen, 165 N.E.2d 756, (N.Y. 1960) Dr. Rosen had achieved considerable success with schizophrenic patients by the device of lowering himself to their level in order to communicate with them. In this case even though the doctor denied it not too convincingly, there was evidence that the patient was actually beaten by the doctor. The appeals court reversed the trial court's dismissal of the malpractice charge and even held that the plaintiff did not need expert testimony in that case.

Another bad case, in my view, came from England. Landow v. Warner, March 7, 1961. There the physician employed the transfer phenomenon, the establishment of a close personal relationship with his patient, to the extent that by most people's definition his patient fell in love with him. This isn't uncommon in psychiatric practice. However, the doctor made the mistake of extending this relationship beyond the analyst's couch and had social contact with his patient. The court held him liable for this, failing, in my view, to realize that the psychologist's therapy can't always be confined to the office. Don't get me wrong. I don't mean to condone cases where a psychiatrist took advantage of his relationship and seduced the patient. There are several of those. In Zipkin v. Freeman, 436 S.W.2d 753 (Mo. 1969), for example, it might be said that there were sufficient grounds to uphold a jury's award against a psychiatrist. During therapy the patient realized she felt nothing for her husband or her family and transferred her affection to Dr. Freeman. She became more and more involved with her doctor, went to parties with him, and tried group therapy, including a nude swimming party. On overnight trips Dr. Freeman undertook to advise her on how to handle an inheritance. He advised her to leave her husband and allowed her to move to his farm, part of which was purchased

with her money. He finally told her to divorce her husband and told her that in order to rid herself of hostility she should break into her husband's home and steal a desk and two beds and take them to the doctor's home. Later she stole some suits and a television set for the doctor. Unfortunately, Dr. Freeman's therapy didn't work. By the time of the trial Mrs. Zipkin still had the headaches she complained of when the therapy began and she still rejected people and she still had guilt feelings. I don't think anyone will weep too many tears for Dr. Freeman although, as I'll point out a little later on, you might weep a few tears for his malpractice insurer because it wound up having to pay the judgment.

So pity the poor practitioner. Not only is he exposed to the classic type of malpractice claim, but he also has to answer for defamation, false imprisonment, libel, failure to warn, and quite often superhuman powers of prediction are being required of him after the patient injures himself or injures someone else. In addition, there are many different standards of care and conduct and to add to the psychiatrist's woes, the claims that are made are usually so bizarre that the insurance companies get skittish and start looking at the policy in an effort to avoid liability. Unfortunately, the policies are written for other types of physicians. The usual policy has a hospital professional liability language and obligate the insurance company to pay and defend suits for "damages because of injuries of any person arising out of the rendering of or failure to render during the policy period the following professional services: medical, surgical, dental, or nursing treatment, furnishing or dispensing of drugs, etc. That doesn't quite fit. I was looking at one file the other day and I saw this under exclusions: "liability of an insured for his personal acts or omissions of a professional nature." This appears to me to unravel in the exclusions paragraph what the coverage of the paragraph was supposed to omit. Most insurance agents will as a matter of course strike that exclusion. But if they don't, it makes you wonder what premiums are paid for.

Additional problems arise when the policy is written, as it usually is, in conjunction with the general premises coverage. Any of us who deal in insurance know that nowadays for premises coverage, or for automobile coverage for that matter, the insured event is an occurrence and an occurrence is defined in terms of an accident neither expected nor intended from the standpoint of the insured. This clause was put in to exclude coverage for a conscious, willful act. I had occasion to examine the history of that clause in Continental Insurance Co. v. Hancock, 507 S.W. 146 (Ky. 1974). The general idea of this clause was to give expression to strong public policy often announced that a person should not be allowed to insure against a willful tort unless the language is very plain. Unfortunately, the language isn't very plain in some of these insurance contracts that are purchased for psychiatrists. For example, unlike the surgeon who didn't mean to leave the sponge in his patient's abdomen, many

claims are made against psychiatrists and psychologists with the allegation that there was an injury or there was an occurrence based on a conscious course of conduct, and that the psychiatrist meant this to happen. Punitive damages are asked, and that's when the insurers start getting nervous. They remember the first opinion in Hancock where the Court of Appeals adopted the rule that punitive damages are not covered under an ordinary insurance policy. They now hold, however, that you are covered for punitive damages if those punitive damages arise as a result of gross negligence. There is a big question now as to whether you are covered for punitive damages if it is alleged and proved that the damages were the result of a willful act. Many claims that I've seen made against a psychiatrist usually include a punitive damage count, and therefore you usually get a letter of noncoverage from your insurer. Just as a practical matter I advise you psychiatrists and psychologists to make it plain to your insurance agents that you want coverage tailor-made to your profession and not pieced together from coverages for other types of activities.

Finally on the subject of insurance most mental health services in our state are rendered by agencies of the commonwealth. As we all know, the commonwealth is protected by sovereign immunity, but individual physicians, administrators, etc., cannot draw the cloak of sovereign immunity around them, and our enlightened state government still does not buy insurance for them. I consider this to be shocking. However, despite all these gloomy insurance problems I might remind you of Zipkin v. Freeman. That case was not a review of the judgment that I knew Ms. Zipkin obtained against Dr. Freeman. It was garnishment proceedings where they attached his insurance policy. Fortunately for Dr. Freeman his policy covered him for claims based "on professional services rendered by the insured." Over a rather vigorous dissent the Supreme Court of Missouri decided that Dr. Freeman was covered because there was some relationship with what he said was "professional services."

Having hung the crepe, let me assure you as a practical matter that psychiatrists make poor targets in a lawsuit. It's still fact that it's awfully hard as a practical matter for a plaintiff to make a case against a psychiatrist and psychologist. There are many practical reasons why these cases are so few and far between. Often a claimant is ashamed to bare his soul in court. It's awfully difficult to show very real emotional damages in a way that the jury will believe it. The plaintiffs themselves are not very attractive people. They're crazy, they're junkies, or they have some other stigma justified or unjustified. But assuming the plaintiff takes the bit in his teeth and files a suit, he still has a hard way to go. To begin with there is a lack of definitive standards by which the courts can tell the jury they can find one way or the others that rights were violated. This is particularly true with respect to standards for diagnostic negligence. For example, in Baker v. U.S., 226 F.Supp. 129 (S.D.Iowa, 1964), a known suicidal was assigned to an open ward and he jumped out the window. The court held in effect that assigning him to an open ward

was a calculated risk which the doctor as a matter of law is entitled to take. A directed verdict was entered.

Another problem is the problem of privileged communication. In Kentucky, communications between a psychologist and a patient are absolutely privileged. They got that in when they put in their psychologists' review law. But when I tried to get a similar privilege for a patient and a psychiatrist, the legislature wouldn't go along, so communications between a psychiatrist and a patient are only conditionally privileged. In any event, the plaintiff has an awfully hard time trying to find willing witnesses and finding records which will substantiate his side of the case.

On the other hand the defendant can and usually does find a convincing witness that will solemnly testify that just about any course of conduct including beatings and wet pack treatments, has the approval of some school of thought or another in the profession, and they can usually sound pretty convincing about it.

Another hurdle that's hard for a plaintiff to jump is proving that some bizarre act on the part of the patient was proximately caused by the malpractice of the physician. In other words, you have to show not only malpractice but you have to show that it was the cause of the injury. If the injury was suffered by the patient himself, our legal concept of volenti non fit injuria--that you won't be heard to complain about something you've done to yourself--is as deeply ingrained in our juries as it is in our courts. If there is some suggestion that a disturbed patient hurt himself, it's awfully hard to hang it on the psychiatrist. I don't particularly appreciate that because I think it's rather ironic that after many, many years the Court of Appeals of Kentucky finally set up guidelines for measuring the standard of conduct of a minor. In other words, they gave you guidelines whereby you can gauge whether or not a minor who was making a claim was contributorily negligent or not. But I don't know of any court that's attempted to give a similar guideline with respect of contributory negligence of a patient. In addition, it's well known that psychiatrists are not liable if injury results from an error in judgment. They can always come in and claim error in judgment. The most extreme case I was able to find involved a child who was assaulted by a prematurely released mental patient and the error in judgment rationale absolved the defendant. That's Taig v. State, 241 N.Y.S. 2d 495. (App. Div. 1963). Now the plaintiff's old friend, res ipsa loquitur--the thing speaks for itself, is seldom ever available in this type of case. Hammer v. Rosen was the only case I could find, and there are many cases holding that things do not speak for themselves in a psychiatric malpractice case. In one case in Kentucky, Wilson v. Lehman, 379 S.W.2d 478 (Ky. 1964), the Kentucky Court stretched a bit to find there was consent when it was obtained from the spouse of the patient and not the patient himself.

We've heard a lot about commitment. I won't go into it in detail except to point out that now commitment has become a quasi-judicial procedure at least in Kentucky, and there are cases which grant immunity to psychiatrists if

they are acting in the capacity of an official participant to commitment procedures. As I said, psychiatrists are not an easy target. I think this is unfortunate despite the horrendous effect that malpractice claims have on the cost of medicine, because the threat of malpractice does tend to keep all types of practitioners, our own profession included, in line. At least one psychiatrist agrees with me. Dr. Hamilton, writing in the Maryland State Medical Journal in an article entitled "Malpractice from the Private Practice and Institutional Psychiatric Viewpoint" said this: "the psychiatric practitioner may be tempted to become lackadaisical and cursory in his application of standards and generally accepted medical and physical principles to the psychiatric and medical emergency which occurs in an area for which he is responsible or to a patient in his care." Most psychiatric hospitals provide proper medical specialty care by qualified consultants, even full time staff members. These persons are not always at hand to manage emergencies. The fact that one is, being a psychiatrist does not relieve one of general medical responsibility as long as one is a licensed practicing physician, especially when an emergency situation arises.

I'd like to conclude with a little commercial or editorial comment. In any state in the country, and certainly Kentucky, more money is spent on prisoners in correctional institutions than is spent on mental patients. Civil rights of prisoners in correctional institutions is a developing field of law but development of civil rights of mental patients is lagging far behind. The development of rights of mental retardation patients is even behind that. As I mentioned, mental retardation is by definition an incurable condition, and yet mental retardates are always lumped together with mentally ill patients and their programs almost are invariably administered by persons trained to administer to the mentally ill, some of whom in my opinion are capable of making the distinction.

There are several cases imposing liability for the acts of a prematurely released patient, but usually these cases arise when the patient has harmed someone else. Nowadays hospital administrators make a big thing of returning the patient to the community. Often as not in a tort case much expert testimony can be marshalled to say that it's a good thing they returned the patient to his family. But I think legislative attention ought to be paid to release procedures. I think we should be sure that there are community services available for the patient before he's released simply to make the hospital statistics look good. I think some attention ought to be paid to the welfare of the patient in addition to the welfare of the people harmed by the patient prematurely released. Incidentally, there's a good annotation on the liability of a person releasing an institutionalized patient for the harm he causes to others at 38 A.L.R. 3d 699.

One or two cases have held that a submissible jury issue was made because a doctor sent a patient to the wrong hospital. I'd like to see more of those cases. Many of our mental institutions are no more than human warehouses. If some liability is attached to the sending of people to these places, there might be some pressure to upgrade these institutions. It's interesting to note,

for example, that the Somerset Institution for Mental Retardation was specifically designed to prevent crowding more and more patients in. I think that the pressure or fear perhaps of malpractice suits just might be one way of upgrading these warehouses that we've seen like the Frankfort State Hospital.

With respect to psychiatrists and analysts, I think some attention ought to be paid to imposing a fiduciary standard of care on them and not a standard made for negligent surgeons and anesthesiologists. While it's been said that physicians have a license to commit manslaughter and lawyers have a license to steal, psychiatrists have a license to commit battery and false imprisonment if that line of thought be followed. Now the law is putting constitutional constraints on this license.

I think it's not without significance that in O'Connor v. Donaldson, a damage case with a verdict of \$38,500 compensatory damage and \$10,000 punitive damages was rendered despite the state official's dissent that he was acting in good faith reliance on state law when he confined a nondangerous mental patient and gave him no treatment. I think the significance of O'Connor v. Donaldson is that it is based on a so-called patient's constitutional right to liberty. The verdict was reversed, by the way, on the very narrow issue of the quasi-immunity of a state official. The fallout from O'Connor may be more damage suits such as Whitevee v. State, 290 N.Y.S.2d 486 (Ct. Cl. 1968) where a \$300,000 award for illegally confining a patient for 90 percent of 14 years was affirmed. I think it should have been. But on the whole I think the fallout will be healthy. It was one impetus that caused Kentucky to rewrite its commitment act. I would take slight issue with Dr. Ruben. He said he would overpredict. I would suggest to you psychiatrists that perhaps if you would err why not err on the side of liberty. But I think we all agree, particularly when we still use danger as a criterion, that we've got a lot to work on as far as commitment is concerned and maybe in time we'll bring our two professions a little closer together as was done in Durham v. U.S. when we finally had a workable definition of insanity in a criminal case. So I'd like to see more attention paid to the constitutional rights of patients to live decently once they are confined. Will it take more damage suits to accomplish this? I hope not. It's an expensive way to make the law. Claims are growing in their variety and their volume. I hope psychiatrists, psychologists, and lawyers will get some fixed frame of reference out of it and maybe some definitive standard of care and treatment.

MR. PROSSER: The lawyers have problems in the field of malpractice too. Let me tell you this about malpractice actions. It is the responsibility of a responsible attorney to filter out medical malpractice cases. The fact there are attorneys sitting in this audience today I think is indicative of the fact that the legal profession is concerned about the increase in medical malpractice actions. Over the past 3 years I've had some 50 cases come into my office of people wanting to sue a doctor. Out of those 50 cases I've filed 2 lawsuits.



One was against a doctor for performing an abortion and one was against an orthopedic surgeon. Just yesterday I wrote a man a letter telling him that after some month and a half of investigation and analysis of his medical records we cannot represent him in a medical malpractice suit because we found no malpractice. I sent that letter certified return receipt requested because I don't want him coming after me claiming that I didn't do a good job either. In addition, over in Louisville there is a case in which a doctor is suing a lawyer because the attorney took on a client who fell out of a hospital window and he sued the doctor. The case was dismissed when discovery disclosed that the patient had been on a furlough, came back to the hospital drunk, and then fell out the window. This to me is probably an indication of irresponsibility on the lawyer's part since he didn't do the appropriate discovery before he filed suit. Sometimes someone will walk in and say, "I've got this great medical malpractice suit. Tomorrow is the last day of the statute of limitations." If someone came into my office like that, I'd tell them, well they'd better spend the rest of the afternoon finding another lawyer. Attorneys are working on the filtering process. You in the medical profession I'm sure are not aware of statistics. None have ever been kept as to the number of people who go running out convinced that they've got a problem that is medical malpractice and the legal profession precludes a suit because they refuse to file it. We'll take a little time for questioning now.

#### QUESTIONS AND ANSWERS

QUESTION: I'd like to respond to a couple of remarks you made. It troubles me when you indicate that maybe one of the ways to improve our state hospital system is to threaten the psychiatrist with more suits. I'm reminded of Wyatt v. Stickney, I believe, or Wyatt v. Alderholt. A number of these class action suits started out with the psychiatrist administrators going along with them. I guess they were called sweetheart suits or something like that. Then things suddenly started to go wrong. The psychiatrist became the scapegoat it seemed to me. I remember in the Alabama case, Judge Johnson found in favor of upgrading the facilities and wrote some standards after getting a lot of input from various people nationwide, and Governor Wallace then refused to give them the money. I mean it was not the psychiatrist, it was the state government. Then, of course, Judge Johnson threatened to take Alabama state lands and sell them, if I remember correctly. On Donaldson v. O'Connor I think the rest of your story is that the damage suits were reversed because the criteria was stated that a doctor couldn't be held accountable for standards that would take effect in the future. I think it was something like that. But I want to make the point that psychiatrists work in a social context. In a way we can only do as much as we're allowed. You made the remark earlier, Mr. Prosser, about the bell and salivating. I think it also works in terms of batting you head up against a wall. I think a awful lot of people who work in the state mental hospital find themselves repeatedly stymied

in implementing new and improved programs if in no other way in terms of funding.

My final remark will be in terms of your law, Mr. Barber, which was recently passed. I thought there were an awful lot of important changes. I was very interested in it. But there didn't seem to be many other people interested. There was nothing in our Lexington paper about it. I really feel that the people we're talking about today are really the disenfranchised minority or one of the important ones in our society. Not very many people speak up too often for the mentally ill people. So that law went through and I felt there was a lot of yawning going on. Most people didn't care.

MR. PROSSER: The fact is that it isn't very newsworthy. I was in the journalism profession and frankly a murder trial seems much more interesting than what's going on here today although what's going on here today is going to have a much more far reaching effect than whether or not the jury comes back with a guilty verdict.

DR. RUBEN: I have several comments. By and large I agree with the remarks that you made, Mr. Bruton. One thing I would like to clarify is my comment about overprediction. When I overpredict, it doesn't necessarily mean I involuntarily hospitalize. I too am quite concerned about the patient's right to liberty, but in terms of overpredicting, the dangerousness of the clinical state of the patient is also important and as long as I'm concerned and sensitive to the fact that the patient may be dangerous, then I think that I won't be perhaps missing dangerous people and letting them slip through and not taking appropriate action which might lead to hospitalization, but surely not necessarily.

One of the other comments that I would like to make in relation to your mention of ECT, wet packs, and insulin shock therapy is your statement that you will be glad when they're no longer in use. This is quite an unfortunate situation. As Dr. Weitzel mentioned, ECT is appropriate in certain emergency psychiatric situations. There's no question that ECT has been overused to some degree in the past and there have been times when people perhaps have been injured because of the use of ECT. What this led to ultimately was the California legislature last year passing laws that said that you could not do ECT without some sort of review board and setting up very stringent guidelines so that it's virtually impossible to have ECT performed in the state of California, in spite of the fact that there's good medical evidence that for certain specific illnesses such as the most severely depressed and catatonic excitement, for instance, that you would use ECT. Wet packs are putting the patient in cool wet sheets, wrapping them up and letting them be in cool wet sheets. At Yale Psychiatric Institute, for instance, which is a long term hospitalization facility for the most severely psychotic individuals, wet packs are still used on occasion when we have people who are recalcitrant to drug treatment. Obviously we use psychotropic medication when possible, but there are times when the patient cannot tolerate the drugs for medical reasons and wet packs are used. I've never known of a patient to suffer from wet packs. With ECT it's true that in the past a number of people suffered physical injuries such as fractures. Currently when

ECT is administered, muscle relaxants are given so that the patient doesn't have the severe violent seizure that they used to have before the advent of the muscle relaxant usage. So I think the physical injuries under ECT are quite rare now. I do agree that at times it's overused and it has been overused in the past. But I think its judicious use is still called for in certain instances.

MR. BRUTON: I didn't mean to intrude on your profession and to rule them out. I know they are still being used, but if, for example, Congress can mandate that technology arise that will make automobiles burn cleaner, should not there be that kind of an emphasis to find other less dangerous physiological drugs for treatment than electric shock therapy.

DR. RUBEN: Obviously I agree, and I think it is not a procedure without risk, but I think that there are times that are quite appropriate for ECT and other types of treatment. The problem in what's happened is just what you're alluding to: that we take from one area, consumer protection, and decide that consumer protection then applies to medical treatment. I don't like having to deal with people where I don't understand what's going on in relation to my car or my t.v. set, and I'd like protection. I think by the same token medical patients deserve protection. But I think it's gone too far when you have to go to a judicial review body in California to see whether or not a certain medical treatment is indicated.

There are two more comments that I wanted to bring up. One was a problem that you alluded to, situations in which the insurance company decides to settle a matter out of court when in fact the physician believes that he has not committed any negligent act, would be willing to go to court, and feels quite certain that he would be able to prove his innocence. But unfortunately the insurance company settles. I've seen that this is an increasing problem recently.

MR. BRUTON: Most medical malpractice policies have a clause in them that settlement cannot be achieved without the consent of the insured. But we lawyers are pragmatists, and we know that a jury can't always understand the fine issues, so sometimes we advise a settlement.

DR. RUBEN: Just one other issue, too. I wanted to ask a question. The 1972 Social Security amendments that established the PSRO, the Professional Standards Review Organizations, also had a civil immunity clause in them that I'm sure you're aware of and that I know has been hotly debated. I wonder what your opinion is about this civil immunity clause as it might pertain to malpractice suits in the future.

MR. BRUTON: In Kentucky you cannot have this type of civil immunity; it must be a federal mandate solely. It might tend to decrease the cost of medicine, and that's the only reason I'm in favor of that provision. On the other hand, I am firmly convinced that the threat of suits is something that should be kept in the background to keep all our professions honest.



PROTECTED RIGHTS OF MENTAL PATIENTS

Oliver H. Barber, Jr., J.D.  
Gittleman, Charney and Fitzgerald  
Louisville, Kentucky

When Dr. Weitzel and I set up this program, I suggested that I go last because I felt that by that time, between Mr. Bruton and Dr. Weitzel, I would have enough rebuttal to keep me going. Fortunately, I agree with most of what Dr. Weitzel says. Although Mr. Bruton is a mean old defense attorney most of the time and I am attempting to become a mean old plaintiff's attorney, we agree on some of the things that he had to say this morning. What I would try to do is focus on that which I know best, the patient's rights when individual patients are involved in psychiatric settings. As the program indicated and as was dutifully read to you by Mr. Prosser, I was staff attorney for a forensic psychiatric unit here in the state of Kentucky. Translated that means that I'm one of the very few attorneys I know who was paid to spend time inside a mental hospital. In 1973 at the time I was on that staff, I was part of the treatment team actively involved in the treatment process as a staff attorney and patient's advocate. I spent a full year in that capacity.

I try to divide patient's rights into two areas. The first area is commitment rights and the rights of individuals as they face the commitment proceedings. I'll talk a little bit about that because that hasn't been touched on this morning. I'll also spend some time talking about the second area, the rights of individuals who are in institutions.

If my 4 years in the Army in The Judge Advocate General's corps as an active attorney taught me anything at all, it taught me that when giving a speech the Army rule is best: you tell them what you are going to tell them, tell them, and then tell them what you told them. Following that rule I'll tell you that I have just one sentence that if I can get across to you I think will sum up what I want to say. Each individual who's involved in the psychiatric-legal process has all the rights that you and I have no matter what has happened to him or what degree of psychosis or what degree of bizarre behavior he was involved in. He or she has the full panoply of every right that you think is accorded to you, accorded to him. Only after procedural process rights have been established and followed may certain things be taken away from an individual patient. Primarily these are concerned with the freedom of movement and the freedom to harm someone else.

In the state of Kentucky the seminal decision that generated the institution of the new mental health law that we have was a decision by Judge Alan, Kendall v. True, decided in February of 1975. In this case a man named Terry Kendall felt that his wife was acting very bizarrely. He claimed that she was running around in the park in the wee morning hours without any clothes on, that she was being hostile, and wasn't taking care of their baby. He took out a mental inquest warrant to have her committed for 60 days to River Ridge Hospital in

Louisville, Kentucky. In talking with her defense attorney, Curtis Stuckey, at legal aid in Louisville, I discovered that Mr. Stuckey's theory is that what Terry Kendall was doing was projecting his particular aberrations on his wife. Mrs. Kendall went down, got herself a legal aid attorney, and went into court to contest the whole civil commitment procedure. During the course of contesting the procedure one section of the statute was thrown out because it didn't have the rights of confrontation, the right to have a hearing before the 60 days were initiated, and also because in the judge's opinion it didn't have a standard for dangerousness built into the statute. As a result of that decision there have been quite a few changes in the procedural due process rights here in Kentucky which I think are mirroring the procedural due process rights all across the United States. For example, in order to commit someone in Kentucky for longer than 72 hours, there has to be a full court hearing. When I say a full court hearing, I mean you have to have an attorney present representing the individual patient, and you have to have the doctor or doctors present and testifying unless that is waived by the individual and his or her attorney. You also have to have a final and full determination of the case by the judge. By that I mean that the court would have to determine in accordance with the statute upon completion of the hearing that the individual is (a) mentally ill, (b) because of his or her illness presents an immediate threat of danger to self or others--and we've already had some discussion to that-- (c) that the least restrictive alternative mode of treatment requires hospitalization, and (d) that the treatment which can reasonably benefit the respondent is available in the hospital.

Breaking that down a little bit, some of the changes that have been brought into this law came from Lessard v. Schmidt 379 F.Supp. 1379 (E.D. Wisc. 1974); vacated 421 U.S. 957 (1975), or at least some of those concepts did. One of the concepts in there and also in Kendall v. True is that the patient has a right to be in the courtroom and has the right to confront his or her accuser. I have heard the argument time and time again that you should not take the patient into the courtroom because most of the time it is detrimental to the individual's mental condition. I do not buy that argument. At the time that I went to work for the forensic psychiatric unit there was that requirement in the Kentucky law, but it could be waived by the doctor through certain magic language such as "it's not in his best interest." At that time approximately 30 patients a month were going through the civil commitment process from the forensic psychiatric unit. None of them were ever given an opportunity to confront the doctors or the accusers or to understand what the judge had to say. The staff was plagued by innumerable questions of why am I here, nobody has ever taken me to court, nobody has ever ruled on me, my rights are being violated. We changed it all around. In the past 2 years there has only been one patient that the doctors have said was so psychotic, so disoriented, or so ill, that it would be harmful to that patient to take him into the courtroom. Consistently, it has proven to be beneficial to the patients to know what is going on with their case.

Another facet of the rights that are protected under our statute and which are accorded in all the state statutes or at least should be is that each individual at any stage of civil commitment beyond 30 days, 72 hours, 3 days, or 48 hours should have an attorney. I was just commenting to Dr. Ruben that one of my major theses is that the biggest problem that I see in the civil commitment process other than the situation where two doctors agree that an individual should be hospitalized without ever seeing him is that most of the time there is not an articulate, well-informed counsel willing to represent the individual rights of a patient at the hearing. It is well known that mental health law does not pay. It was stated here this morning that no one was interested in the passage of the Kentucky mental health law of 1976. It's further felt that these people are basically disenfranchised. I believe that after the emergency commitment of 72 hours when you come to the hearing, if at the hearing you have the patient, you have a patient's attorney who is reasonably well-informed on psychiatric jargon, reasonably well-informed on what is going on with the patient, and is willing to act as the patient's attorney--not just accept what the doctor says--and you have two psychiatrists who are willing to testify as to their opinion based upon observable facts that they had seen or read in the file, and a reasonably competent judge who is willing to make the decision, then from there on many of the problems that you would have on habeas corpus actions or violations of rights actions would fade. I further contend that if you follow this concept and work together on the front end as doctors and as lawyers for well-informed members of the bar, for a well-informed physician and a well-informed judiciary and put this money on the front end, that it would save a lot of money in the long run. Money would not be expended for lawsuits, money would not be expended for treatment that doesn't work because the patients are recalcitrant, hostile, upset, and staff time would also be saved.

One of the things that I think it is necessary to understand concerning patient's rights is some of the history of the patient's rights concept. You've heard a rather chilling narrative, at least from my standpoint, from Dr. Weitzel this morning concerning the evolution of the civil commitment laws in the United States. Initially the individual who was "insane" in old England was made a ward of the King. I think you'll find, however, if you read some recitations of how this worked that only those individuals who had some land and who "went berserk" or weren't able to care for themselves or their land came under the king's wing. This concept come down through the law and through the medical profession and was translated into something called parens patriae here in the United States.

At the same time that he was writing this article in 1960 or a few years thereafter a man named Kenneth Donaldson had some kind of falling out with his father, and he was hospitalized at the state hospital at Chattahoochee, Florida, which is a huge place. It is, if you'll pardon my statement, one of the largest mental hospitals in the world outside the Soviet Union. At the Chattahoochee

Hospital he was placed on the forensic psychiatric ward. As you read his account of his trials and tribulations, which was in the Fifth Circuit opinion, you'll find that he says that he spend every night before he went to bed praying that some of the crazy people in there who were charged with very serious crimes would leave him alone so that he would be able to wake up in the morning. He was a Christian Scientist and he refused their medication. He told them that he would partake of individual counseling, that he wanted occupational therapy, and that he wanted grounds privileges so that he would have an opportunity to pursue what he thought were reasonable means to show the individuals that he could live in society. He was denied all of these things for a number of years. For example, one of the statements in the Fifth Circuit opinion was that over a 10 year period one of the staff physicians may have treated him only for approximately 8 hours during this 10 year period. That doesn't translate to very many minutes per year.

Evidently, as Mr. Bruton has told you, the jury believed the man and after Dr. Morton Birnbaum and the National Mental Health Law Project took the case and brought the damages suit, he was released. They dropped the class action and he recovered in damages. Then the case went on up through the Fifth Circuit where it was affirmed and a constitutional right to treatment was delineated. Just as in the Kendall case, Chief Judge Wisdom indicated that parens patriae is dead.

I suggest to you that after the decision was rendered by the Supreme Court in Donaldson v. O'Connor 422 U.S. 563 (1975), what you have is a statement that you may not simply incarcerate or warehouse a patient in a mental hospital without treatment unless there is a showing that that patient is dangerous. Donaldson v. O'Connor would take mental hospitals in the state of Kentucky and empty out of them every single patient who is not dangerous and whom it cannot be shown is receiving adequate treatment for their type of mental illness carried to its logical extreme. I further contend that if you take Kendall v. True, apply the precepts of the Fifth Circuit opinion--which has been overruled to a certain extent--and the logical extension of the Donaldson case, then even the dangerous people, if they are committed, have to be treated. If you don't do these things, what you really have is some kind of preventive detention which has been stricken in court decisions in the District of Columbia and elsewhere.

One of the factors that you have to consider in the treatment concept is what type of treatment is good treatment. As has been indicated this morning, there are many psychiatrists who would be willing to support various theories, behavior modification programs, chemotherapy, and all of the other types of programs. If you go to Wyatt v. Stickney you will see listed reams and reams of ideas on what are the basic proper treatments, patient staff ratios, what type of program should be available to the individual patients and concepts and ideas on how to implement those programs. That case had a very interesting genesis. There was a new director of the state mental hospital system down in Alabama in 1972, Dr. Stonewall Stickney. Dr. Stickney was interested in finding a way to balance



his budget. He took a look at the system and said, "What am I paying the most for?" He says, "I'm paying the most for salary, as in any mental hospital situation. I'm obviously not paying the most for the food and the housing of the patients; it's for the salaries of my staff. Who makes the most money? The people that make the most money are the psychologists and the psychiatrists and the social workers, not the aides." He looked at his situation and he said, "I can't fire a whole bunch of aides in order to save money because if I do that I'll have nobody to take care of the patients. I'll have somebody to counsel them and perhaps treat them but I'll have nobody to take care of them." So he fired 150 professionals, social workers, psychologists, psychiatrists. When he did that, then the professionals said, "By George, he's hurting these people's individual treatment programs. We're the only treatment programs that the hospital has." In particular this was the cry of the psychologists because at that time there was quite a controversy between the psychologists at the University of Alabama at Tuscaloosa and the psychiatrists who were running the hospital. They found a very flamboyant attorney from Alabama to come in and bring a lawsuit in the name of Ricky Wyatt. So the genesis of this particular lawsuit was not some parading civil rights attorney strolling through the south looking for wrongs to be righted, but a very simple economic issue on the part of the professionals who'd been fired. As a result you had those standards that are put forth in Wyatt v. Stickney.

Some of the concepts that we have heard concerning the rights of patients have been embodied in recent litigation. Some of the litigation would be the Lessard case, for example. Those concepts all start with one basic assumption, that each patient should be entitled to humane care and treatment to the extent that the facilities, equipment, and personnel are available in accordance with standards accepted in medical practices. I believe that the quote from the Wyatt case is that each patient should receive care or treatment which would give them a reasonable opportunity to improve his or her condition. If you start with that basic assumption, you start with the concept from the very outset that the patient knows he's going into the hospital. Then the patient should be consulted immediately concerning the treatment program that he or she is going to be involved in. The patient should be adequately and duly informed of what's going to happen to him and should be asked to make suggestions in terms of his or her own treatment. It is my contention--and I'm stepping into the realm where Dr. Weitzel and Dr. Ruben can really get in some licks--that the great majority of people who are admitted on a court order to a mental hospital are disoriented, and psychotic, seriously disturbed, or whatever you want to call it in only a certain area of their ability to see and hear and understand. Most of the people that I've seen are not so totally out of it that they can't give you some kind of interaction on their program. Those people are the individuals to which this statement applies.

Thereafter there should be a treatment program drawn which will give some type of realistic opportunity to cure or improve the individual patient's health. This goes back to the original statement that I made to you concerning the four

things that the judge has to find before he decides to commit someone to a hospital. He has to find on medical testimony given in court that the patient can reasonably benefit from that hospitalization. There's a hooker in this statement. The hooker is that in the Diagnostic and Statistical Manual you'll find a listing of antisocial behavior. It's not called psychopath or sociopath any longer. It's antisocial behavior, and it has its own little number like all those things in the DSM.

The individual patient has to be able to be treated to a certain extent. What does that mean? Does that mean that if the diagnosis is antisocial behavior that the individual patient does not belong in a hospital, that where he belongs is in the jail or he belongs in prison? That's a very interesting question because one of the jobs that I had when I was with the forensic unit was to assist the doctors in figuring out a way of releasing a very dangerous individual whom they had made a final determination after 6 years was not psychotic, was no longer schizophrenic and did not have an organic brain syndrome, but all he was was mean; antisocial personality was the final diagnosis. They came to me and said they would release this man. I said that under the definition of the statute, the Diagnostic and Statistical Manual would list that as a mental disorder and if it lists it as a mental disorder and we release him, you might be violating the statute. If you violate the statute, you're going to be in real trouble if he kills someone.

I went to him and I said, "Let's talk about this." We talked about it for a while. He said he wanted out and didn't care what they called him and that he was going to get an attorney to get out. I said that's beautiful. I went back to the doctors and said now look, are you reasonably certain that this man is going to harm someone else if he's released? They said they were as reasonably certain as they could be based on a long history of violent assaultive behavior both inside and outside. I was able to find an attorney to represent him and we had a habeas corpus hearing. I was able to get enough information on the record to protect my doctors. The individual attorney was able to get enough information on the record to get his patient out. The patient went out. We got him a roommate. He stayed with the male roommate for 2 days, stole a suit of clothes, wound up in prison, and I've lost track of him.

Another aspect of patient's rights inside of a mental institution is that I believe that each patient has the right to refuse the treatment program accorded to him. That has a caveat on it. If you take Dangerous Joe and put him in the hospital and Dangerous Joe goes over and sits down in a chair and starts communing with God and God tells him do not take any of this medicine because it is going to poison his mind, and Dangerous Joe on the outside assaulted all four members of his family and was threatening to kill half a dozen neighbors with a gun, but he's inside the mental setting and he's not doing anything that's dangerous, simply because he's inside that setting, do you have the right against his will to give him the thiorizene which would help him?

In this situation when the staff came to me I said, "Let's work with him for a while." They said, "It's a pain; we can't spend all this time with him." I said, "Look, it's a whole lot more pain for me going to court and have the judge throw me out when I come in because it's not in the statutes to have him order this man to take this medication." So they worked with him for 2 weeks and came back to me and said you're going to have to go into court. So I got all my petition prepared, and I went into court and I submitted it to the judge. I was prepared to make my argument and the judge looked at me and said, "I'm a Christian Scientist, I can't order this." That actually happened. He said, "I'll lay it over 2 weeks." I said "Judge, it really shouldn't make any difference." He said, "I'm a Christian Scientist; I can't handle this." So I went back to my staff and said you have to work with him for 2 more weeks because there's nothing I can do. The judge won't even listen to me. So I went back 2 days later and we sat down and I said, "What's the thing that he likes best in the whole world?" They said he liked two things best in the whole world, playing bingo with the little girls that come over from St. Agnes Parish on Wednesday nights and smoking cigarettes. I said, O.K. "Who's providing him the money to buy the cigarettes?" They said "We are." I said, "I don't see that the man has a constitutional right to require you to give him money to buy cigarettes." So one of the staff members went over to him and said that if God tells you you shouldn't take medication then we're telling you that we're not going to give you any more cigarette money. And furthermore you can't play bingo on Wednesday night because that's what we call an extra added attraction. He took it for 2 days then came over and told the staff that God had changed his mind. He took the medication, and I didn't have to go back into court.

The object of this story is that in 90 percent of the cases--and that's purely my figure, I can't document it except by my own personal experience--there's a way to talk the individual into taking the medication or cooperating with the treatment program. In 10 percent of the situations where that is not available, then hopefully your hospital, be it state or private, will have a responsible, aggressive attorney who will try to figure out a way under the present statutes or under some type of theory to go into court and try to get the medication order. Dr. Weitzel and I discussed this type of fact situation before and there's disagreement on my theory here. One of the countervailing theories is that if you place someone in a hospital by a court order who's dangerous, the quid pro quo is that you're going to treat them so that they are no longer dangerous. Therefore you should be required by the original court order to give them the medication if that's what it will take. I argue that's stretching it too far.

One of the aspects of the new mental health law which is not included that was included in the Lessard case was the Miranda warning right. I didn't put that in there and no one else saw fit to put it in there either, because it was my intention that when an individual is admitted to a psychiatric unit, it doesn't really make any difference whether or not the psychiatrist spends a lot of time

talking to him. If the psychiatrist and/or the treatment team does an adequate workup based on information they can get from the outside and spends a significant amount of time watching the individual behavior on this particular unit, most of the time they should be able to come to some type of feel or some type of informed opinion on the case. I've been told this; I've also been told that that's ridiculous.

There's been a particularly aggravating aspect of this problem that just occurred here in the state of Kentucky. There was a woman--and all this is in the public record--named Charlotte Edwards who was just tried for murder in Louisville, Ky. It appears that she'd had long term psychiatric problems and had been hospitalized quite recently. I guess she was hospitalized in the early part of September or October. In November or December or so she went out to a local shopping center and without having much cause and no connection at all with the individual, she shot a Major from Ft. Knox to death. One of the aspects of that case that is really tragic from the standpoint of Charlotte Edwards only--I know it was a great tragedy to the family of the Major but from her standpoint--she was placed at the forensic unit for diagnosis and evaluation. She was extremely paranoid and refused to talk with the psychiatrists. She refused to cooperate with them in any way. She said she would not cooperate unless her attorney told her to do so. Her attorney chose not to do so. One of the contributing factors to her conviction, and what is going to be her subsequent long term incarceration unless there's a successful appeal, is the fact that nobody took evidence of the counselors and the individual aides at the psychiatric unit concerning her behavior while she was on the unit. The psychiatrist took the stand and testified that he, during the course of her care there, did not personally observe any psychotic behavior or indicia of symptoms of psychosis. That was accurate. And he was not allowed to testify concerning other things that other people had seen. I'm not convinced, as wild as I may be about patient rights, that the Miranda warning is a good thing. I think by and large most of the people who are going to be committed to a hospital are going to have the opportunity to talk to someone and they're going to do it and I don't think it's really necessary to warn them that whatever they say may be used in civil commitment procedure or some other types of civil action against them that pertains to their staying in the hospital.

In conclusion, I want to go back to what I originally stated. Except for certain strictures of protecting individuals inside and outside the hospital setting from violent behavior by a person and except for certain strictures on movement, every single right that you have is reserved to the individual mental patient. If you can focus on that concept, I think you'll find that if you apply that concept, you'll have better treatment programs, you'll have more work or individual therapy perhaps, but in the long run it'll be a lot less expensive than having to deal with me or people like me who are coming from a background of horrendous decisions and horrendous fact situations in mental health law who feel it necessary to get involved in litigation in this area.

QUESTIONS AND ANSWERS

MR. PROSSER: Let's open up the questions to the entire panel in case anything has come to you.

MR. BRUTON: When I listened to you talk about all these new rights that need to be respected, I have two responses: (1) Who's going to pay for it? I say that in a real way because the way the present system is staffed and funded has to bear the brunt of these new agendas. You're going to have even more good people leave the system rather than be bogged down in it. I understand, for example, in terms of the treatment plan, the development of which our committed patients under this new law are going to be able to participate, that the Department of Human Resources is floating the current idea that within 3 days the patient will be provided with the written report of the assessment and the problems in the proposed treatment plan and that the patient at least once a month will be given a written progress report which the patient will be able to discuss with the physician. It seems an awful lot of new bureaucratic work; I'm afraid there isn't new money to pay for that and it discourages me a great deal.

DR. WEITZEL: Let me answer that new money business. I consider this to be a cop-out. It's a cop-out that we've heard excusing a multitude of sins and a multitude of violations of civil rights. There is a case that I consider to be in point. The state of Iowa was sued in district court and the state legislature was ordered to raise sufficient tax money to provide pupils in special education with the type of education to which they were constitutionally entitled. So the short answer to your question is that the state legislature should pay for it. To say we don't have the funds is a cop-out.

DR. RUBEN: May I comment please? I agree with what you're saying, Mr. Bruton, but I also agree with Dr. Weitzel. I myself am quite pessimistic about the current political situation in relation to some of these issues. That doesn't mean that I'm throwing in the towel or copping-out. For instance, in relation to what Mr. Barber just said, I agree with him totally about the problems in the current commitment procedures. I think that what he outlined as reasonable procedure I too agree is reasonable, but I'm afraid that I see it pessimistically as pie in the sky. I don't want it to be that way, and I want to do anything that I can to help change it. But the current situation is that in my own experience a great number of judges who deal with these matters don't understand enough about psychiatry to understand what the issues are. As you point out, a number of the attorneys don't and unfortunately a number of the psychiatrists who come into court don't know what they're talking about either. The reason I say that is that coming into court is a very unpleasant experience for anyone, and especially for a psychiatrist who's supposed to know what he's talking about and yet is dealing in intangibles, is dealing in matters of opinion where very frequently you can get another psychiatrist who has a different opinion and rightfully so. Most of the cases that come in about commitment are coming in from state hospitals. The worst of the mental health system unfortunately most of the time shows up in the

state hospitals. That's not always the case, but more foreign trained physicians who don't speak English adequately--and you know this and I know this, end up in the state hospital system--physicians as we've said here, who really don't have any idea what our commitment laws are, physicians who don't understand the legal issues. Good doctors unfortunately--and I hate to use that term--but I think that the most competent physicians are unwilling to go into court a lot of the time. In this past month I spent 3 hours in jail interviewing one patient for the public defender in New Haven and then I spent about 3 hours writing a report. The state of Connecticut only wants to pay \$75 for a psychiatric evaluation, I submitted a bill to the public defender for what my time was worth, which was far more than \$75. I don't know whether I'll get paid. The problem is that good psychiatric expert testimony is hard to come by and it's expensive. I spent another 16 hours this month in court in a conservator proceedings where a very competent attorney is trying to protect a large estate and rightfully so. I was the defendant's witness. The problem is that it's possible to spend a lot of time and money in a situation where the judge really didn't understand what was going on and there were a lot of medical issues that I was there trying to explain that hopefully will allow this patient to protect her own rights. Other attorneys, the plaintiff's attorney, didn't understand either, from my medical perspective, and a big case was made out of something which needn't have been that way. The problem is, I think, that the whole system needs to be reformed, and I think it calls for legislative reform at the highest level. I think that's going to take a lot of money, and I'm quite pessimistic because I see the current administration cutting back on money for different types of mental health reform and underwriting different types of research, the sorts of things that the criminal justice and the legal system will need to be able to come up with the right kinds of answers. I surely don't have an answer myself, but I'm very concerned because I don't see the right kinds of reforms coming.

I just want to comment on two other things, the Diagnostic and Statistical Manual which you poke fun at Ollie, is an inadequate system and is currently being revised. It's an offshoot of the international classification of disease that's been set up by the World Health Organization and other people, and it's necessary for statistical purposes and research purposes and also unfortunately for purposes of third party reimbursement because there are payments available from insurance companies for different types of illness. You have to classify people; as psychiatrists we don't like to classify people, but we're constrained to do that. There is also in the DSM, category number 318 which is no psychiatric disease found, so that you wouldn't necessarily have to classify everyone as having a psychiatric illness.

A lot of the time, in my experience, we're able to get people who are gravely disabled to accept voluntary hospitalization and a lot of that has to do with the type of relationship that the professional sets up with the patient the minute the patient walks into the office. Someone can drag a patient in saying

you have to lock this person up, and there's a lot of heated feelings between the patient and the family, and the patient is dead set that they're never going to go into the hospital, especially since mother or father is telling them they've got to. But a lot of times if I can get that family member out of the picture and sit down and talk to the patient about what's going on and what's been happening to him and discuss with him why hospitalization will be appropriate and one of the things is to get them away from the spouse or parent who's driving them crazy, I've had a lot of success getting people to accept voluntary hospitalization. So even when someone wants us to involuntarily hospitalize in many of the cases, and again this is impressionistic--I don't have any hard data--a large percentage will accept voluntary hospitalization.

MR. BARBER: I think that's true. It's an excellent point. I should have alluded to it, and I think a classic example of how that can be done, and this is a stroke for you Dr. Ruben, is the four cases that you cited this morning. A lot of psychiatrists in all four of those cases would have gone for civil commitment and to your credit you were able to work it out in the first three without having to resort to that.

QUESTION: I think the issue of separating hospitalization and treatment as two separate categories is absolute nonsense. Hospitals and physicians have rights, too. One of their rights is not to have to act as a detention center. There are much less expensive places where this can be done. In my opinion any judge whom I would respect would not be willing to take a list of proposed psychiatric treatments which are recommended and say, "All right give that one." A sensible judge would realize that this is not his area of expertise.

QUESTION: In the new laws did they make a provision to pay the attorneys for representing these people in court? In other words, the court appoints a lawyer to represent the person charged with incompetency. Did they make provisions in the new law to pay the attorneys for their time and effort.

MR. BARBER: When I wrote the law I wrote it so that a public defender could be appointed to do that. I've been told in conversations that I've had with the public defender that no funds were provided to accomplish that objective. I don't know whether that's true or not because I have faithfully requested from the legislative research commission copies of the bill, and they have so far not seen fit to send it to me. Mr. Bruton has had exactly the same problem.

MR. BRUTON: I have a copy of the bill. I've read it, and I haven't seen anything about monies for it.

MR. BARBER: I think that might be included in another bill that I requested which would be the new bill that was passed concerning just public defenders.

DR. RUBEN: I wanted to make one comment in relation to this gentleman's comment about separating treatment and hospitalization. I'm not sure if I understood your comment totally, and I'm not sure who you were addressing your comment to either, but I had some feelings about it. I know that Mr. Barber said something about having various treatments that could be recommended. I think in terms of a major

revamping of the commitment system and the question of monies, if the law stipulated that the attorneys for the defense and the plaintiff's attorney, whatever, depending on the matter, would be paid a certain fee and if the experts were to be paid a certain fee and if the expert testimony would come in to help the judge understand rather than trying to discredit, the experts perhaps might agree on different types of treatment that might be appropriate. Rather than the judge sentencing or remanding for treatment, a specific treatment at least could be decided upon. If there were a certain range of treatment that might be appropriate, the judge would be in a better position to decide that treatment was appropriate and, given the least restrictive alternative doctrine, whether that treatment needed to be offered in a hospital or on some sort of out-patient basis.

MR. PROSSER: There is a provision in the statute and in the civil rules for an expert to be appointed in the defense of a person whether it's in a criminal case or a commitment case. I had occasion in a criminal case recently to seek a forensic pathologist in a case for which I was not receiving a fee although it was not a legal aid case. The judge said "Mr. Prosser, I'll be more than happy to appoint a forensic pathologist for you if you can find one and if you can find the money, because the rule specifically says the court may appoint someone and pay them out of available funds. But the funds aren't available." The point is the money isn't there, and we in this room are not the people who are going to get the money. Unfortunately it's going to have to be courts that are going to have to order us to sell public lands or raise taxes or do something else to do what the legislators should be doing in the first place.

QUESTION: I have one brief comment perhaps on the money situation. There was a case from the District of Columbia which relied on an earlier Supreme Court case, Goldburg v. Kelley, 397 U.S. 254 (1970) to hold that in a case of mentally retarded children, the money had to be divided equitably between retarded children and those who were not handicapped. Although the state had a legitimate right to preserve its funds, it had to do so in an equitable manner so that all people in society would benefit equally from it. Of course, saying that in a decision and implementing it are two different things.

I want to direct a question first to Ollie Barber. You mentioned that under the new law if there's going to be a commitment for greater than 72 hours, there has to be a full court hearing, and the court must find those four separate elements that you mentioned. I want to know what standard of proof is required? Does the court have to decide by a preponderance of the evidence or beyond a reasonable doubt?

MR. BARBER: I wrote it to put beyond a reasonable doubt, but that was taken out. I don't remember that there is any standard of evidence specifically delineated in this statute.

QUESTION: Secondly, Mr. Bruton mentioned, by way of opinion I think rather than by reference to any particular legal precedent, that it would be impossible to have a beyond a reasonable doubt standard in a commitment hearing. I'd sort of



like to throw this up to the panel both through a legal and a medical side to discuss what kind of standards, practically speaking, you can expect in order to preserve the rights of the patient and still not totally foul up the system where people do need help.

MR. BRUTON: You're perfectly correct. That was my opinion, but it's based on pragmatism. How can you have something that is so subjective. How can you prove something that is beyond a reasonable doubt? It's just an unworkable criterion. You're going to get all kinds of opinions. It's a matter of opinion. You cannot prove opinion evidence beyond a reasonable doubt. I submit to you that it's an unrealistic criterion to impose on an area where there aren't any standards any-way.

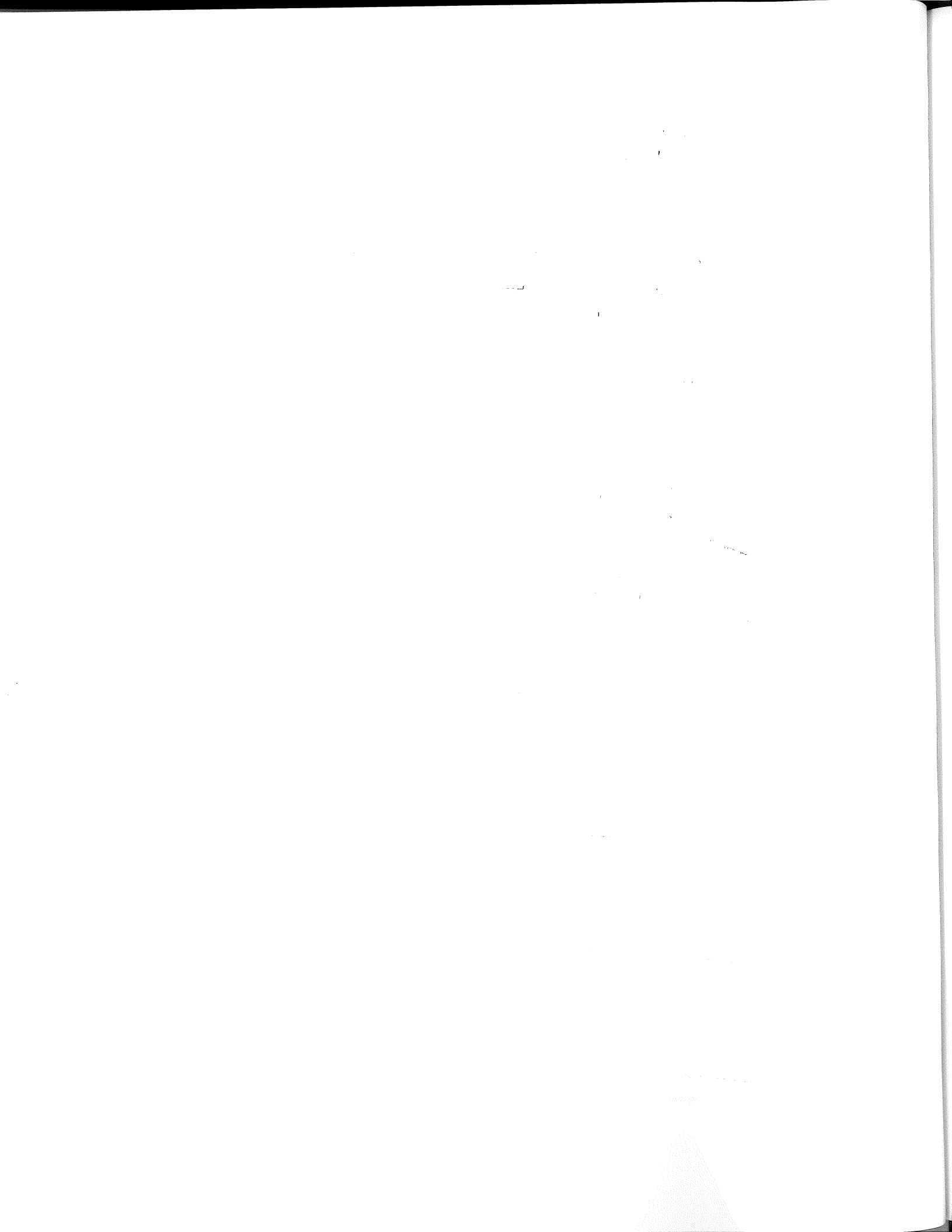
QUESTION: However, there is precedent for it.

MR. BURTON: That's right, there is a precedent for it, and I don't have to accept all precedents either.

QUESTION: I'd like to address this comment or question either to Dr. Ruben or Mr. Barber. Yesterday we went into some depth on arbitration and malpractice which is a pet project of mine even from years ago when it was unpopular. Is there some place for this in the commitment proceedings or in the rights of patients in the absence of judges who understand or is there legislation that would be appropriate?

MR. BARBER: As far as I know, and Mr. Bruton just read for us my feeling on it, there's no particular statutory language that would lead to that arbitration proceeding. I'll tell you that I have a particular case now where a young lady claims that she was improperly kept in a private hospital in one of the major cities in Kentucky. What we're interested in is not a lawsuit. We just want to find a vehicle to sit down and discuss the procedures of the hospital with the physicians so that this type of thing doesn't happen again. I think even though the statute doesn't provide for it, arbitration and mutual discussion is very, very important.

DR. RUBEN: I'd go a step further to say that I think you're making an excellent suggestion and perhaps that's really what's needed rather than adversary proceedings of some sort, arbitration proceedings that would allow the parties to sit down and try and make a determination.



PERSONAL INJURY LITIGATION

Joe C. Savage, J.D.  
Turley, Savage and Moore  
Adjunct Professor of Law, College of Law,

Honorable L. T. Grant  
Chief Judge, Fayette Circuit Court  
Lexington, Kentucky

William G. Winter, M.D.  
Assistant Professor of Surgery, Orthopedics  
College of Medicine

Robert J. Turley, J.D.  
Turley, Savage and Moore  
Lexington, Kentucky

William D. Grubbs, J.D.  
Woodward, Hobson and Fulton  
Louisville, Kentucky

Charles Landrum, Jr., J.D.  
Landrum, Patterson & Dickey  
Lexington, Kentucky

As part of the seminar on Law and Medicine the simulated examination and cross-examination of an expert medical witness was conducted. Because the most valuable aspect of this part of the seminar was its actual performance, it has not been reproduced. Participants in the examination were Judge L.T. Grant, of the Fayette Circuit Court; Dr. William G. Winter, Assistant Professor of Orthopedic Surgery of the College of Medicine; Robert J. Turley, of Turley, Savage and Moore of Lexington for the Plaintiff; William D. Grubbs of Woodward, Hobson and Fulton of Louisville for the Defense; and Charles Landrum, Jr. Landrum, Patterson and Dickey of Lexington, for the Defense.

STATEMENT OF THE FACTS OF THE CASE

MR. SAVAGE: If you'll look in the seminar outline, you'll see a synopsis of facts of this hypothetical trial. We have styled the case Mickey Green, an infant suing by and through his father and next friend Ed Green, against the defendants Tom Dunn and Acme Motor Express, Inc.

This is a suit for personal injuries by this young boy against the driver of a truck and the company that owns the truck. The boy received the injuries when, as he alleges, he was walking along a narrow strip of grass next to the street. The truck came to an intersection on that street and made a turn. Its trailer wheels tracked inside, came across onto the grass, struck the child, and knocked him into a culvert. The defendant's allegation is that the young boy ran out to the street to chase the rear wheels of the truck and became entangled in them.

The part of the trial that we want to stage this afternoon includes the medical testimony of the treating doctor, Dr. Spring. Dr. Spring treated this

young boy from the first and helped him through his initial injuries. He has opinions, and will express these opinions to you, as to what the future holds for this young boy, Mickey Green.

It's important before we start to explain to you how the case has reached the point where the treating physician is ready to take the stand. Of course, the young boy and his father went to see counsel and the attorney agreed to represent them in the case. The Acme Motor Express, Inc. and its driver, Tom Dunn, retained counsel and that defense firm is present. The case has proceeded through the usual filing of the complaint and the answer, and the pleadings were then completed.

Next, discovery proceedings have taken place so that each side knows what the other has in the way of facts. In the process of that discovery, for example, counsel for the defense has taken the deposition of Dr. Spring and basically knows what the doctor is going to say at the trial.

In the course of preparing for trial, the defendant's counsel also had the opportunity to have this child examined by a physician of his own choosing. That examination was performed by a hypothetical orthopedic surgeon by the name of Dr. Daniel. The plaintiff's counsel then had an opportunity to take the deposition of Dr. Daniel, which was done in this instance.

That brings us to the trial. In reality, we would have started this trial this morning. The plaintiff's counsel would have made an opening statement outlining the theory of the case and what the plaintiff expected to prove. That would have been followed by the defense counsel's opening remarks. Then the plaintiff would present evidence to try to prove the case. The first witness would have probably been either the little boy or his mother or father. That would be followed by an eyewitness to the accident, or other liability-oriented witnesses. Now we've had our recess for lunch and we're ready to continue the trial and the next witness will be Dr. Spring.

#### PANEL DISCUSSION

MR. SAVAGE: In this discussion I'll call upon each of the participants in the trial, beginning with the judge and then the witness and then the attorneys, to ask for their comments. Then let's throw it open to questions and see what's on your mind.

I think in this trial we see one of the problems of the law of evidence in Kentucky. That problem concerns how certain a physician must be of his opinion before he is allowed to give it, on a question about the future course of a particular patient. That leads us into a discussion of "reasonable medical certainty," as it was phrased.

The key on this is Rogers v. Sullivan, 410 S.W.2d 624 (1966). The real issue arises after you've established that there's negligence, causation, and an injury. You then begin asking the doctor what's going to happen in the future to this boy, because after all this is his only day in court. The jury has to give

him an award that will be fair for the rest of his life. Must the doctor talk in terms of certainty? May the doctor talk in terms of probabilities? How are probabilities defined? Mr. Turley says it means more likely than not. I've heard some lawyers say 51 percent.

The Rogers case brought all this up. It was a shoulder case. The lawyer asked the question this way. "Based on the fact that it has now been some 16 months subsequent to the time he sustained his injury, and that there is presence of atrophy, what would you say his possibilities are for complete recovery?"

Judge Palmore overruled existing case law that said the question has to be answered in terms of medical certainty. He said that the phrase "reasonable probability" is the preferred expression. But in the opinion he never really defined what probability meant. The clue is that he said that in any case where you're trying to prove damages, the plaintiff has to take the issue out of the area of speculation. An analysis of the facts and holdings of the cases supports the conclusion that courts have used the term "certainty" to mean only that the fact of damages must be taken out of the area of speculation. So I think that test is really whether the doctor is speculating or not.

Let me now ask Judge Grant for his opinion with respect to the trial as he observed it.

JUDGE GRANT: When you get into the area of probability versus certainty, I think we have to consider what we're dealing with. We're dealing with an expert witness in the medical field. Some standard, I suppose, would have to be set in order for him not to testify on matters of speculation. Our Supreme Court has defined that standard to be probability, but the definition of probability is a very difficult area. Mr. Turley during the trial attempted to get into some speculation on how this injury would affect other people, not from a probability standpoint but from a possibility standpoint. But we need some standard, I think in order for the medical expert to testify.

One of the doctors posited, for instance, that if you deal in percentages, probability means 51 percent. What about a man whose doctor says he has a 40 percent chance of dying? Is that probability? I feel that if a case gets to the Supreme Court with a set of extreme facts like that, perhaps they might define probability as such.

DR. WINTER: For the physicians in the audience, I'll comment that I share a large concern about what the whole area of litigation--not just malpractice--is doing to our society for a host of reasons. One is that I seem to see some of my physician friends spending more and more time concerned with litigation. It seems to me we'd all be better off if somehow we were again able to focus on productivity more progressively.

As far as today's mock trial goes, I'll just add one further question. If I treated someone with eight or nine injuries--and that is a regular part of my practice--and there is a 20 percent chance of residual injury here and a 30 percent chance there, then we're really playing the numbers game. We could add

them all up and come out with a total possibility of just one of those things going wrong for the patient. That happens, too. It's obvious that the law can distort reality for whatever necessary purpose. As far as I'm concerned, all I can do is do my damndest not to distort reality.

The two areas that cause the most problems here are when I'm in the embarrassing situation of having to admit holes in my knowledge and when there are limitations to medical knowledge. All you can do is come up with the best opinion you can and then document it by the best facts that you have.

MR. SAVAGE: We'll now let Mr. Landrum give us his comments.

MR. LANDRUM: I want to say two things. First, in a case like this where a child is hurt as badly as this child was, when you are a defendant's lawyer, you want to minimize the injury as much as possible. A defendant's lawyer should never ask a question unless he knows what the answer is going to be. I asked one question on which we got a speech from the good doctor. I should not have asked it, but I did anyhow. I did that to demonstrate how a lawyer can literally be gutted by a doctor by opening the door, giving him the opportunity to make a speech.

I wish to make another comment in response to Judge Grant. He stated that we are dealing with expert witnesses. I differ with Judge Grant. I do not believe that a doctor who is an attending physician is an expert witness any more than an eyewitness to an accident is an expert witness. The doctor who attends that patient owes an obligation to testify as to what facts he found as attending physician the same as the eyewitness to an accident is required to testify as to what facts he saw. That's a realm that doctors and lawyers have been differing about for a long time, but that's my opinion. I think he's a factual witness, not an expert witness. Until he is asked what his opinion is as to the future of that patient, he is not an expert witness. I believe that is the point where a defendant's lawyer may, if he can, properly attack the doctor's judgment by showing that it is a matter of expert opinion upon which learned men disagree.

MR. SAVAGE: I'll now call on Mr. Grubbs for some comments.

MR. GRUBBS: When defense is cross-examining a physician who is as knowledgeable and as capable as Dr. Winter is, he should get on and off as quickly as he can. I prefer, where there is a real difference of opinion, to present it through my own medical witness. Unless I feel that he has taken a position that I can clearly dispute with many case studies, I won't go after the witness. That's just my own approach. I prefer a low-key cross-examination. In the cross-examination today, I tried to take what I thought was our weakest area, namely the nonunion of the fourth metatarsal, because I wanted to bury it in the middle of his testimony. I wanted to end with some points where the doctor was agreeing with me. I also took the plaintiff's exhibit, and where it had been marked in red to show a fracture, I took a blue marking pen to show that those areas had healed. Again, that's just a little thing that will sometimes make an impression on the jury.

MR. SAVAGE: I might add that one of the things the audience may or may not have observed is that the key to any successful practicing of a case is through pre-

paration. This keeps the doctor, in a sense, consistent with his colleagues in any particular area. If a doctor departs from the standards of the profession, a well-prepared lawyer can bring him up short and make him explain why he holds a different view than most of his colleagues. Mr. Turley, give me the closing remarks from the plaintiff's counsel.

MR. TURLEY: First, I think the key to the direct examination of any expert witness is a pretrial conference with that witness in which the lawyer sits down with the doctor and explains to him just exactly what is expected of a physician when he's called to testify--what parameters the law provides with respect to expert testimony beyond the scope of which the physician is not permitted to go. The lawyer should also tell him what he proposes to ask on direct examination. Obviously, the pretrial conference is used for other purposes as well.

The second point I would like to make arises from what Dr. Winter said. He said that physicians have become more and more concerned with litigation. That, of course, is true. For the benefit of the physicians, let me say this in defense of my profession. Law simply means an authoritative verbalization of society's minimal values. It's no more than that. The purpose of jurisprudence is to adjust, in as satisfactory a manner as can be done, the differences that develop between people in any sort of a society or a community. So the law and the lawyer have as their purposes in society to serve as the lubricant by which people can live together and at the same time as the cement by which the society can be held together.

Most often the choices are not between what's right and what's wrong; the choices are between the rights of one citizen and the rights of another. The choices become even more difficult when they involve some forecast of the future. This is the reason we get into opinions. At one time the old Court of Appeals talked about the requirement of proving future damages with reasonable certainty. This led to the use of the phrase "reasonable certainty" in interrogating doctors. And doctors, as explained by Dr. Winter on the stand, have a different notion of certainty than lawyers.

Lawyers are more pragmatic in that they know we can't solve disputes unless we can talk in terms of something less than certainty. So the law has come to the point where we talk in terms of reasonable probabilities. That has become the code phrase in interrogating an expert as to his opinions about the future.

We tried to point up today the next choice that we think the courts will have to make. I join Judge Grant in believing that if the right case is taken to the Supreme Court, we'll have a decision which will deal with this problem: that is, how one can show a jury, assuming evidence of a permanent condition resulting from an accident or an injury exists, that no one knows what will happen, but that there are many complications, none of which occur more than 50 percent of the time so that the doctor can't predict anything definite. There may be six different complications, the incidence of which may run from 5 percent to 30 percent. Bearing in mind that the plaintiff is in court only this one day,

isn't it fair that the jury be able to consider in some fashion the incidence of possible complications of his condition? We're casting about for a method by which that can be shown.

MR. SAVAGE: We'd like to entertain questions from the audience if we could do so now.

QUESTION: Mr. Landrum, is it not possible to call a doctor as an expert or as an ordinary witness, and can you examine him under the rules of both?

MR. LANDRUM: A doctor is subject to subpoena the same as any other person. There is a misconception in Kentucky that a doctor doesn't have to go to court if he doesn't want to. That's not so.

QUESTION: Do you subpoena him as an expert?

MR. LANDRUM: Either as an expert or as a factual witness. It depends on whether he's a factual witness--if he's an attending physician to testify to the facts that he found when he examined and treated the patient. Where he leaves the realm of a factual witness and becomes an expert and you ask him what the extent of residual injuries are, then he becomes an expert because he's expressing an opinion. It might be a very expensive one, depending on where he's from.

QUESTION: Could you ask him to give an expert opinion if he were called as an eyewitness?

MR. LANDRUM: No. Whether he's an expert or not depends upon his qualifications. If he's a gynecologist and comes upon the scene of an accident and attends a broken leg, he would not be an expert orthopedic surgeon; he was a factual witness in that he found a man with a broken leg lying on the side of the road.

DR. WINTER: Does a physician in a situation like that have the right to decline the mantle of expertise if it's offered to him by an attorney?

MR. LANDRUM: Yes.

QUESTION: Mr. Grubbs, you had a book ready to bring out against the so-called Dr. Spring if he didn't agree with what you could find in the literature. Is this fair? I presume it's legal.

MR. GRUBBS: The distinction has always been that an accepted treatise can be used for purposes of cross-examination if the witness accepts it as a generally recognized treatise. Even though it's a generally recognized treatise, the witness still may say that he disagrees with a certain portion of it. By saying it's generally recognized, he's not undertaking to vouch for the accuracy of every page. The law is in flux right now on that. Our state Supreme Court recently handed down an opinion which indicates that an accepted text can be used as substantive evidence and not just for impeachment. The interesting thing is that the book that I had didn't have anything to do with the proper way of measuring leg shortening under 1/2 inch. That was just something I'd run into in another case recently. The book that I had dealt with standard criteria for evaluating disability. What I did have but didn't get a chance to use, simply because the doctor was very candid and stuck to the script, was the deposition. That's where the physician must often becomes tripped up. He expresses an opinion



in his deposition that is slightly different from what he expresses at the trial. Then the deposition is used for purposes of impeachment.

QUESTION: Judge Grant, I'm speaking about the plaintiff's schematic exhibit. Were the predesignations which located areas of alleged injuries on plaintiff's exhibit drawn prior to its introduction.

JUDGE GRANT: This particular diagram was used in an actual trial and that's the reason the red marks were on there when it was introduced. Ordinarily, my opinion would be that the diagram ought to be introduced with nothing on it.

QUESTION: Thank you, Judge. Bob Turley, could you have prevented defense counsel from drawing on your exhibit his self-serving comments? That exhibit might accompany members of the jury to the jury room.

MR. TURLEY: In a trial, had I objected to his having marked "healed" on my exhibit, I might have been sustained, but that would simply have attracted more attention to his having done so.

QUESTION: Could you not have gone to the judge and asked him out of the jury's audience to direct defense counsel not to do that? The jury might possibly feel he would have no right to mark up the exhibit anyhow.

MR. LANDRUM: Well, it's matter of judgment in a particular instance. If he tried to stop me from writing on it, I'd say, "Well, he has healed hasn't he?"

JUDGE GRANT: One way to get around the objection would be to have the doctor himself come down and mark the areas that have been healed.

MR. SAVAGE: Do we have any other questions?

QUESTION: I've been in Dr. Winter's situation where plaintiff's attorney did not tell the doctor in the pretrial conference about the second expert's opinion. I think the expert witness used by the plaintiff's attorney should always know what the defense medical witness is going to say. In this trial, Dr. Winter's position was weakened when the defense attorney read Dr. Daniel's statement which did, of course, contradict Dr. Winter's opinion. The second question is, this was a damage suit, right? How long are you allowed to bring a damage suit for a minor?

MR. SAVAGE: Until the 19th birthday. We have a one year statute of limitations in personal injury actions, and it does not run out on a minor until he reaches 18.

QUESTION: I ask the plaintiff's attorney, since the probability of future damage to this child is somewhat in doubt as demonstrated by this trial, would it have been better to advise the plaintiff not to bring this case until the child became of age? Maybe this child would have had symptoms of arthritis by the time he was 18 or 19, in his hip and almost certainly in his foot. Then plaintiff would have solid grounds for a higher settlement.

MR. TURLEY: A agree. Bear in mind that in a case like this, one must prove liability as well as damages. Witnesses move away. They die, they forget. There is a risk that you'd lose on the liability even if you did have better evidence as to the residual injuries.

QUESTION: I'm afraid this may be a trivial question, but since the facts of the case initially revolved around whether the little boy was on the grass or on the

street, why didn't anyone ask the expert witness if grass was found in the wound? That might have solved the whole thing right there.

MR. LANDRUM: Dr. Winter said he found grass, rocks, mud, and dirt in the wound.

QUESTION: Aha! Grass was there. Doesn't that prove something?

MR. LANDRUM: No. Because he was thrown from the wheel into the grass. That's where they found him.

MR. SAVAGE: We lost that case once. It's very painful to bring that up again!

## PROFESSIONAL ETHICS & ADVERTISING

Leslie G. Whitmer, J.D.  
Director, Kentucky Bar Association

### I. The history of the ethic prohibiting advertising by the legal and medical professions.

The word "professional" is hard to define, but it has, as a vital element, the interest of the public above personal gain. Robert N. Wilkins, in his 1938 book entitled, The Spirit of the Legal Profession, made a statement about professions that is particularly significant today in relation to members of the legal and medical professions advertising their services. Mr. Wilkins stated:

The professional spirit sets its seal against self-seeking and self-aggrandizement. It awakens a social consciousness and conscience. It tends to inspire men with the zeal of the scientist, the devotion of the saint. It teaches that by the advancement of men wise and good all men prosper.

"Advertising" has always been a bad word among lawyers and physicians. Codes of ethics for the medical and legal professions have always contained strict rules against advertising, as we commonly think of that term. The rules have served the public well. In that they have spared both from the excesses often committed in the name of advertising. The negative connotations to the word "advertising," however, should not overshadow the duty of the professional to permit informative communications about his services with the public he serves. It is to the public's advantage to receive information from the professions in order that a person can make an intelligent selection of a physician or lawyer.

While both physicians and lawyers are professionals and have a common interest in ethical prohibitions against advertising, it must be realized that the two professions have one great dissimilarity--lawyers are officers of the court. They are officers charged with the administration of justice within the third branch of a free, independent democracy. This distinction may, in future litigation prove to be significant in the area of advertising restrictions.

Professional codes of ethics are receiving intense review in the field of advertising prohibitions. The pressures for change are mounting at an alarming rate. If the customs of the past are healthy, they will survive. If they are weak and self-serving, they will fall.

### II. Pressures demanding change in prohibition against advertising.

The wave of consumerism is challenging prohibitions against advertising on two grounds, as evidenced by federal court suits in some five states against bar association imposed prohibitions. The first ground for litigation in both the legal and medical professions is that the prohibitions serve as a restraint on trade in violation of the provisions of section 1 of the Sherman Antitrust Act. The second ground for litigation is that the prohibition inhibits first amendment rights of the U.S. Constitution, as applied to the states through the fourteenth amendment, concerning the right of free speech, press and assembly. It is even

being argued in the legal clinic of Jacoby and Meyers in California that the prohibition cuts the consumer from receiving information through the news media from a lawyer--one of the most fundamental guarantees in the constitution, it is alleged. The suits challenge the validity of Canon 2 and DR 2-101, 102 and 103 of the Code of Professional Responsibility.

Canon 2 imposes a duty on lawyers to assist the legal profession in fulfilling its duty to make legal counsel available. The duty includes facilitating the process of intelligent selection of lawyers.

The American Bar Foundation and the American Bar Association special committee to survey legal needs will soon publish a final report showing what the committee's chairman, Randolph Thrower, stated is the long-suspected fact that tens of millions of Americans of moderate means, who have legal problems and know it, do not seek legal counsel because they do not know how to find a lawyer and they are afraid that they cannot afford one. As far as the legal profession goes, an argument can be made that consumers must have more information about lawyers.

What then are the legal implications of prohibitions against the market place type of advertising by physicians and lawyers?

### III. Advertising prohibitions may violated Sherman Act.

Consumer groups consider the Goldfarb case the first opening of the door to expose the professions to all customs of the open market place, including unlimited right of the "professional" to advertise his services.

Before we talk about Goldfarb v. Virginia State Bar, 95 S. Ct. 2004 (1975), however, we should refer to Northern Pacific Railroad v. United States, 356 U.S. 1, 4 (1958). In that opinion, Mr. Justice Black, speaking for the court, stated: "[T]he unrestrained interaction of competitive forces will yield the best allocation of economic resources, the lowest prices, the highest quality, and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic, political and social institutions." With that general philosophy in mind, the Supreme Court considered the Goldfarb fact situation. It was a flagrant one. Some 20 lawyers were contacted by the Goldfarbs in an effort to obtain a fee quotation to do a title search. The same fee was quoted by all 20 lawyers and some stated that they clearly would not charge less because of the minimum fee schedule of the Fairfax County Bar Association. The local fee schedule was not in any way adopted by the state bar, which is an agency of the Supreme Court of Virginia just like ours in Kentucky. Still the Virginia State Bar has issued ethics opinions, the same ones that we issued, saying that if a lawyer habitually charged under the minimum he would be subject to disciplinary action. The Goldfarbs maintained in their lawsuit that there had been a violation of section 1 of the Sherman Antitrust Act; in other words, price fixing. They asked for an injunction against the use of the fee schedule in joining both the state and local bars and also asking for damages. The Federal District Court found for the Goldfarbs. In doing that they dismissed

the state bar as a party on the state action theory; that is, where a governmental agency restrains trade, it is exempt from the Act. The court did hold the local bar liable, however, the case went to the Court of Appeals and it reversed the district court except as to the state bar portion of the opinion. It agreed that the state bar was covered by the state action exemption and said further that the local bar was not engaged in interstate commerce because the practice of law did not involve interstate commerce. It also held that bar schedules had insufficient effect on interstate commerce to come under the act. The Supreme Court went along with the district court and held the local bar liable and also held the state bar liable. It reversed on four grounds. I think it is essential that we look at each one of those grounds and analyze each of them because together they lay the foundation for federal court intervention into state regulation of all professions, not just the legal profession.

The first of the four grounds was price fixing. The Court said that Goldfarb was a classic illustration of price fixing, that the fee schedule was not advisory, and that it was not fee information on past standards, but was rather a standard for the charging of fees in the future. It found that a rigid price floor was established. The Court also found that local bar associations and the state bar had enforced the fee schedule at least through its ethics opinions if not through direct disciplinary action. Second, the Court found that the minimum fee schedule had an effect on interstate commerce. It was found that in Virginia on most residential property, money came from outside of Virginia so interstate commerce was involved. Third, the Court said that there is no "learned profession exemption" under the antitrust act. The Court said that Congress did not intend a sweeping exclusion and in fact there was a presumption against application of the exemption. It was held that the nature of the occupation of practicing law and the public service involved, the lawyer being an officer of the court was immaterial. The opinion said that there was, in fact, important commercial intercourse in any competitive activity that may exert a restraint on trade involved in the fact situation. Finally, they said that minimum fee schedules are not state action. In the Goldfarb case there clearly was no state action as such. There was no statute, and there was not court rule approving a fee schedule. The same condition existed in Kentucky. In fact, the Supreme Court of Virginia, like the Supreme Court of Kentucky, had adopted the American Bar Association's Code of Professional Responsibility that stated under the fee provision that the fee schedule was one of some eight items to be considered in determining a fee. So that was probably the weakest defense that the state bar had.

The decision went on to say, however, that it was very limited in its action in regard to professions. The opinion said that the decision intended no diminution of the authority of the state to regulate its professions, to set standards, and to police itself.

Again, consumer groups, and even the American Bar Association, are of the firm belief that the Goldfarb case places the heretofore "untouchable professions" in the commercial market place to the extent that present advertising restrictions serve as a restraint on trade.

On December 19, 1975, the Federal Trade Commission filed a complaint against the American Medical Association, the Connecticut State Medical Society, and the New Haven County Medical Association. The complaint alleged violations of section 5 of the Federal Trade Commission Act and that the proceeding was in the public interest, specifically, the commission charged that the respondents were engaged in business and through the publication and enforcement of the AMA Principles of Medical Ethics, had entered into an agreement to prevent or hinder competition among medical doctors in that it prevented members from:

1. Soliciting business, by advertising or otherwise,
2. Engaging in price competition, and
3. Otherwise engaging in competitive practices.

It is further stated in the complaint that these acts and practices had the following results:

1. Prices of physician services were stabilized, fixed, or otherwise interfered with;
2. Competition between medical doctors in the provision of such services was hindered, restrained, foreclosed and frustrated; and
3. Consumers were deprived of information pertinent to the selection of a physician and of the benefits of competition.

The case is scheduled for an October 1976 hearing before an administrative law judge.

The position of the Antitrust Division, United States Department of Justice, on advertising by lawyers is clear. Deputy Assistant Attorney General Bruce Wilson, in an address before the Philadelphia Bar Association early this year, stated:

Advertising by the legal profession has traditionally been limited to law lists. I suggested, last June, that perhaps this was unwise, and perhaps, if pursuant to an agreement, illegal. I suggested that some forms of advertising might indeed be beneficial.

#### IV. Advertising prohibitions may be unconstitutional.

It has been traditionally held that the constitutional protection of free speech does not extend to delivery of legal, medical, or financial services by persons not licensed to render those services. It has always been held that the states, under their health, welfare and police powers, have the right to control the practice of professions and place reasonable restrictions on their activities. The prohibitions against advertising by a profession came to the United States Supreme Court in 1934, in the leading case of Semler v. Oregon State Board of Dental Examiners, 294 U.S. 608. In this case, Oregon, in regulating the practice of dentistry, enacted a statute banning the advertising of professional service, the performance of professional service in a superior manner, advertising prices or fees, employing or making use of advertising solicitors, the use of certain

types of signs, etc. Semler attacked the statute as overbroad, and repugnant to the due process and equal protection clauses of the 14th amendment. He stated in his complaint, that he had advertised his practice in newspapers and periodicals, stating the prices he would charge and represented he had a high degree of efficiency and was able to perform his services in a superior manner. Of course, he alleged that his advertisements were truthful and made in good faith. Further, he claimed that by these methods he had developed a large and lucrative practice, and thereby he had been able to standardize his office practice, and so establish a uniform scale of charges for the majority of his operations. The latter argument is being advanced in courts today. By advertising their services and fees in newspapers and the media, it is argued, practitioners will be able to reach the poor and middle classes who are now disadvantaged, because they cannot afford expensive legal costs and do not know how to reach competent lawyers. Thus, they will thereby increase their volume of business, so they can use more paraprofessional employees, thereby lowering the cost of legal services and serving a great portion of the unrepresented public. The Supreme Court answered this argument by saying:

The legislature was not dealing with traders in commodities, different standards of conduct from those which are traditional in the competition of the market place. The community is concerned with the maintenance of professional standards which will insure not only competency in individual practitioners, but protection against those who would prey upon a public peculiarly susceptible to imposition through alluring promises of physical relief. And the community is concerned in providing safeguards not only against deception, but against practices which would tend to demoralize the profession by forcing its members into an unseemly rivalry which would enlarge the opportunities of the least scrupulous. What is generally called the "ethics" of the profession is but the consensus of expert opinion as to the necessity of such standards. It is no answer to say, as regards appellant's claim of right to advertise his "professional superiority" or his "performance of professional services in a superior manner", that he is telling the truth.

Lawyers, physicians, and dentists are subject to control and regulation by the legislature and the courts. The courts have uniformly held lawyers subject to their control, in their admission to the Bar, in discipline and the standards of conduct by which they must abide. With the formulation by the American Bar Association, the Code of Professional Responsibility and its adoption by the courts, advertising, except as narrowly permitted by the code, has been proscribed.

In determining the effect of the 1st amendment on advertising, the Supreme Court carefully distinguished between commercial and noncommercial advertising. In Valentine v. Chrestensen, 316 U.S. 53, it held commercial advertising is not protected by the free speech and press clauses, and noncommercial advertising is protected.

In Pittsburgh Press Co. v. Pittsburgh Commission on Human Relations, 413 U.S. 376, the Pittsburgh Press used an advertising system in its daily newspaper whereby job opportunities were published under headings designating job performances

by sex. Upon an appeal from a cease and desist order of the Pittsburgh Human Relations Commission that such classification of ads was violative of the city ordinance against sex discrimination, the Court in a 5 to 4 decision, held the ordinance valid and not a violation of the freedom of the press, because the advertising was commercial.

It is plain that the advertising proposed by the plaintiffs in the various cases pending in the courts is one way of soliciting business. The question is whether such advertising is commercial and therefore not protected as free speech under the 14th amendment. In NAACP v. Button, 371 U.S. 415, the court had before it for consideration the validity of a Virginia statute forbidding soliciting of litigation.

The NAACP engaged in a program of soliciting for persons to become plaintiffs in school desegregation cases. The NAACP maintains a legal staff for this purpose. Typically, in school desegregation cases, a staff lawyer will address a meeting of parents and children to explain the legal steps necessary to achieve desegregation. He will bring to the meeting printed forms authorizing him and other NAACP or defense fund attorneys to represent the signers in legal proceedings to achieve desegregation.

Virginia has had statutory regulation of unethical and non-professional conduct by attorneys since 1849. These provisions outlaw, among other things, solicitation of legal business in the form of "running" or "capping." The statute was amended to include as "capper" or "runner", an agent of an individual or organization which retains a lawyer in connection with an action to which it is not a party or has no pecuniary right or liability.

The Virginia Court of Appeals upheld the statute as a reasonable regulation of the legal profession and was located to strengthen the existing statute to control the evils of soliciting legal business. Upon writ of certiorari, the Supreme Court, by a 5 to 4 decision, reversed, holding the statute violated the 1st and 14th amendments, of free speech and assembly.

Justice Brennan, writing for the majority, stated:

We meet at the outset the contention that "solicitation" is wholly outside the area of freedoms protected by the first amendment. To this contention there are two answers. The first is that a state cannot foreclose the exercise of constitutional rights by mere labels. The second is that abstract discussion is not the only species of communication which the constitution protects; the first amendment also protects vigorous advocacy, certainly of lawful ends, against governmental intrusion. The decisions of this court have consistently held that only a compelling state interest in the regulation of a subject within the state's constitutional power of regulation can justify limiting first amendment freedoms. Thus it is no answer to the constitutional claims asserted by petitioner to say, as the Virginia Supreme Court of Appeals has said, that the purpose of these regulations were merely to insure high professional standards and not to curtail free expression. For a state may not, under the guise of prohibiting professional misconduct, ignore constitutional rights.



The rationale of the opinion is that NAACP and the defense fund, in soliciting for people to start suits in desegregation cases, engaged in a political activity protected by the 1st and 14th amendments.

The court concluded:

Although the petitioner has amply shown that its activities fall within the first amendment's protections, the state has failed to advance any substantial regulatory interest, in the form of substantive evils flowing from petitioners' activities, which can justify the broad prohibitions which it has imposed.

Justices Harlan, Clark, and Stewart dissented, holding the statute was a permissible regulation having its origins in the long standing common law prohibitions of champerty, maintenance, and barratry and the canons of ethics against soliciting, stating that the state's felt need for regulation of professional conduct may reasonably extend beyond mere "ambulance chasing."

Three cases followed NAACP which are important in two respects. They further chipped away at the canons of ethics and showed the concern of the Court toward attorney's fees. In these cases the majority opinions relied on Button's application of the 1st and 14th amendments. Brotherhood of Railroad Trainmen v. Virginia, 377 U.S. 1, and United Transportation Union v. State Bar of Michigan, 401 U.S. 576, involved the same union under different names. In order to assist the prosecution of claims by railroad workers injured or killed on the job, the union maintained a department of legal aid counsel. Under its operation the union selected lawyers to represent claimants in railroad personal injury cases. When a worker was injured or killed, the secretary of the local contacted him or his widow, recommended against the claim being settled without first seeing a lawyer, and advised consulting the lawyer selected by the union. The State Bar of Virginia sought an injunction restraining the union activity as a violation of the solicitor rule. In a 6 to 2 opinion by Justice Black, the Supreme Court reversed a decree of the Virginia Supreme Court barring the union's practices. In his opinion, Justice Black relying on Button, reiterated that a state cannot foreclose exercise of constitutional rights by labels, and then stated, what "Virginia sought to halt is not commercialization of the legal profession which might threaten the moral and ethical fabric of the administration of justice."

In dissenting opinions, two justices stated that the court by this opinion overthrows state regulation of the legal profession and relegates the practice of law to the level of a commercial enterprise.

In the Michigan transportation case, after the Virginia court amended its decree in accordance with the court's decision, the Michigan Supreme Court entered a decree similar to that of Virginia. This decree was also reversed in a 5 to 4 decision by Justice Black, with the observation, "The state bar's complaint appears to be a plea for court protection of unlimited legal fees."

The third of this trio of cases is United Mine Workers v. Illinois State Bar Association, 389 U.S. 217. This case involved the right of the union to hire

a lawyer on a salary basis to handle workmen's compensation cases for its members. The Illinois court enjoined the union's activity as constituting the unauthorized practice of law. The Illinois Supreme Court affirmed, overriding the contention that the union's activity was protected under the free speech and assembly rights of the 1st amendment. Consistently, Justice Harlan wrote a strong dissent against the erosion of the state's power to regulate in the maintenance of the high standards within the legal profession.

In summary, the court's earlier holdings that commercial advertising is not protected by the 1st and 14th amendments has been modified, so that some commercial advertising is protected depending on the nature and purpose of the advertisement. Whether a statute or ethical canon proscribing certain conduct and activities, including members of the bar, will be violative of the 1st and 14th amendments will be subject to the balancing principle expressed in Button and the subsequent cases.

In Cohen v. Harley, 366 U.S. 117, a disciplinary action for soliciting, Justice Harlan said:

It is no less true than trite that lawyers just operate in a three-fold capacity, as self-employed businessmen as it were, as trusted agents of their clients, and as assistants to the court in search of a just solution to disputes. It is certainly not beyond the realm of permissible state concerns to conclude that too much attention to the business of getting clients may be incompatible with a sufficient devotion to duties which a lawyer owes to the court, or that the "payment of awards to persons bringing in legal business" is inconsistent with the personally disinterested position a lawyer should maintain.

In Goldfarb, Chief Justice Burger stated that it is relevant in determining if a particular restraint violates the Sherman Act, whether the restraint operates upon a professional as distinguished from a business. In the concluding paragraph, the court stated:

We recognize that the states have a compelling interest in the practice of professions within their boundaries, and that as a part of their power to protect the public health, safety, and other valid interests they have broad power to establish standards for licensing practitioners and regulating the practice of professions. We also recognize that in some instances the state may decide that "forms of competition usual in the business world may be demoralizing to the ethical standards of a profession." [Citing Semler v. Oregon State Board of Dental Examiners] \* \* \* The interest of the state in regulating lawyers is especially great since lawyers are essential to the primary governmental function of administering justice, and have historically been "officers of the courts." \* \* \* In holding that certain anti-competitive conduct by lawyers is within the reach of the Sherman Act we intend no diminution of the authority of the state to regulate its professions.

In Bigelow v. Virginia, 44 L. Ed. 2d 600, a case in which Bigelow published an ad for abortions in New York, he was convicted of violation of a Virginia statute making it a misdemeanor by the sale or circulation of any publications encouraging or prompting the procuring of an abortion. Justice Blackmun in a

7 to 2 opinion said:

We conclude, therefore, that the Virginia courts erred in their assumption that advertising as such was entitled to no first amendment protection and that appellant Bigelow had no legitimate first amendment interest \* \* \*

To the extent that commercial activity is subject to regulation, the relationship of speech to that activity may be one factor, among others, to be considered in weighing the first amendment interest against the governmental interest alleged. Advertising is not thereby stripped of all first amendment protection. The relationship of speech to the market place of products or of services does not make it valueless in the market place of ideas.

The U.S. Supreme Court just decided the case of Virginia Citizens Consumer Council v. State Board of Pharmacy involving a state statute prohibiting prescription drug prices. It stated that advertising is protected under the first amendment although it may be regulated under different standards than noncommercial activities. The Court specifically stated its decision did not limit the rights of the states to license and regulate to ensure professional conduct. The court specifically stated the decision did not apply to the medical and legal professions, which may require consideration of different standards.

V. The position of the American Bar Association on Advertising.

Under the 1969 ABA Code of Professional Responsibility, still effective in Kentucky under the provisions of RAP 3.130, lawyers can only place their names, the fact that they are a lawyer, addresses, and telephone numbers in telephone directories and yellow pages in geographic areas where the lawyer resides and/or practices. A lawyer may place biographical data and areas of concentration or limited practice in ABA approved law lists. Of course, law lists are not readily available to the public at large.

The ABA Ethics Committee, earlier this year, caused an uproar in the legal profession by recommending to that body's House of Delegates that lawyers be permitted to engage in any type of advertising as long as it is not "false, fraudulent, misleading or deceptive." Enforcing such a provision with discipline would be impossible because of its ambiguity. Fortunately, the ABA Committee on professional discipline skillfully amended the proposal only to permit lawyers to put information into law lists, legal directories, directories published by bar associations, and the yellow pages. In addition to the essentially biographical information now permitted under the 1969 code, an attorney may, under ABA guidelines, list: 1) a statement of legal fees for an initial consultation; 2) availability of a written schedule of fees or an estimate for a specific service; 3) whether credit cards or other credit arrangements are permissible; and 4) office and other hours of availability.

The form and language of any published information must be the same for all lawyers in any given state.

Justin A. Stanley, ABA President-elect, has stated that he is "opposed to commercial advertising by lawyers beyond that now permitted by our code (after

the February amendments)."

Each state must adopt or reject the ABA amendments adopted at its February 1976 meeting. The Virginia State Bar Association, an agency of the Supreme Court of Virginia, in view of being sued by a consumer union under the 1969 code, prohibits publication of lawyers' fees and specialties in law lists, recommended to its state's supreme court the adoption of the new ABA amendments. The state supreme court rejected the recommendation.

The Michigan State Bar Association is taking a middle ground in its recommendations. Its proposal will limit the number of items permitted for publication to:

- (1) Name, name of law firm, if any, and legally related public office held, if any;
- (2) Business address and telephone number;
- (3) Whether or not available for private practice (if not, no further information to be given);
- (4) Extraordinary office hours, if any;
- (5) Age and date of admission to practice in Michigan;
- (6) College degrees other than law degree and where earned;
- (7) Where law degree received;
- (8) Areas of concentration in practice of law if and when certification or selection thereof is approved by state bar assembly;
- (9) Whether or not each lawyer will consult for the initial conference on any matter at the limited fee or not more than \$10 for the first half hour;
- (10) Fluency in any foreign language.

#### VI. The position of the American Medical Association on Advertising.

A statement on advertising and solicitation by physicians, reaffirming longstanding policy, was adopted by the AMA judicial council at its meeting in San Francisco in April. The council said the AMA's Principles of Medical Ethics "are intended to discourage abusive practices which exploit patients and the public and interfere with freedom in making an informed choice of physicians and free competition among physicians."

In its statement, the judicial council points out that "the principles do not proscribe advertising; they proscribe the solicitation of patients." Physicians may furnish information to the public through "the accepted local media of advertising or communication which are open to all physicians on like conditions," the council stated. As examples it gave office signs, professional cards, dignified announcements, telephone directory listings and reputable directories. The council said the information could include the physician's name, type of practice, office location, office hours, and other information "that will enable people to make a more informed choice of physician." If the physician chooses to supply fee information to a reputable directory, the council stated, the "data may include his charge for a standard office visit or his fee or range of fees for specific types of services, provided disclosure is made of the variable and other pertinent factors affecting the amount of the fee."

The council defines "solicitation" in the principles as "the attempt to obtain patients by persuasion or influence using statements or claims which (1)

contain testimonials; (2) are intended or likely to create inflated or unjustified expectations or favorable results; (3) are self-laudatory and imply that the physician has skills superior to other physicians; or (4) contain incorrect or incomplete facts, or representations or implications that are likely to cause the average person to misunderstand or be deceived." The Kentucky Medical Association adopts the position of the Judicial Council of the National Association.

VII. The position of the Kentucky Bar Association.

At its regular board meeting on January 16, 1976 the board of governors of the association adopted a resolution in opposition to the proposed rules of the ABA Ethics Committee and any other action by the ABA to commercialize the practice of law and inserting a commercial interest into the client-attorney relationship. The resolution supports other possible means to provide useful information to the public to assist the public in finding appropriate counsel including a statewide lawyer referral service. The KBA has a committee studying the ABA code amendments relating to advertising. The committee should report to the Board of Governors at its July meeting. The Board will make such recommendations to the Supreme Court of Kentucky as it deems appropriate.

VIII. Benefits of communication and evils of advertising.

The evils of professionals advertising are reflected in the humor of Art Buchwald when he wrote an ad for "Madman Dr. Kelly" announcing the greatest surgery bargain in history to the first 100 people who showed up at his Wesley Heights clinic on George Washington's birthday. The lucky patients were to be given a complete operation, including anesthesia and post-operative care, for only \$2. Other bicentennial bargains offered by Dr. Kelly included a brain operation for \$14.95, a kidney transplant for \$29.50, and a complete blood transfusion for \$3.95.

This was not an example of a communication to assist the public in obtaining competent services, of course, it was an advertisement. It was unprofessional. It clearly had a solicitation goal.

A communication designed to inform a member of the public of qualified professionals to meet either their legal or medical needs is beneficial. Perhaps our respective professions should be more careful in their deliberations to use the word "communication" rather than "advertising."

IX. The future.

The advertising issue will be decided by the courts. There may be a distinction made between the right of a physician to advertise and the lawyer's right. Lawyers are government officials in that they are officers of the court on which the administration of justice depends. I believe that the KBA will be slow to recommend changes in the Code of Professional Responsibility; however, it may be more diligent in discovering methods to inform the public of the availability of competent counsel through a program of legal specialization and perhaps a statewide lawyer referral service. Ultimately, I believe the U.S. Supreme Court will hold that the legal and medical professions are not businesses; therefore, advertising, as we know it in the business world, is not a right protected

by the 1st and 14th amendments. From the antitrust position I believe the Court will not permit commercial advertising by lawyers or physicians. Such findings would seem to be in the best interest of the public we work to serve.

Court  
ings

PROFESSIONAL SERVICE CORPORATION--PROS AND CONS

Robert E. Rich, J.D.  
Taft, Stettinius and Hollister  
Cincinnati, Ohio

The subject of professional corporations and whether a practice should be incorporated are subjects that are receiving a lot of attention these days. The basic choices involved in incorporation are the same for lawyers and doctors. It eventually boils down to the question of how the professional is going to manage and invest the income from his practice. I think every professional in this day and age will have to consider whether or not to incorporate his practice. If he's already incorporated, he must consider what to do with this monster that he may have on his hands.

There are no automatic formulas for incorporation. Not all physicians and not all lawyers should be incorporated. But there are many who should, depending on the facts and circumstances that surround their practice, their lifestyle, and their age. Age is a very important consideration.

I'll give you one word of warning at the beginning: you should beware of advisors who come to you with a set, established program. Not all doctors should be incorporated, but some doctors should not get by without incorporating.

There are a number of problems that can be encountered in professional incorporation. The mere mention of the words "accumulated earnings problem" or the "unreasonable compensation problem," sound horrible. They can be pretty bad, even for technicians and tax lawyers. I could make your hair stand up with stories about those problems. But I don't think you should shy away from the subject just because those technical problems are there. Most, if not all, these problems can be solved by proper planning.

There's a great deal of literature on the subject of professional incorporation. Back in the middle 1960's the articles were all saying not to incorporate because the Internal Revenue Service was against it and there were potential problems such as unreasonable compensation and personal holding company status. In about 1969, however, the IRS decided they weren't going to be against it because they lost six or seven cases in a row. Then the articles began to say that perhaps incorporation was the thing to do. There was a great rush then for professional incorporation. I think some people incorporated who should not have.

Now I'm seeing articles in publications such as Medical Economics and even our professional law journals to the effect that as a result of the changes in the Keogh Plan by the Pension Reform Act of 1974 maybe incorporation is not such a good thing anymore. However, I don't think that you can leave your financial future up to the article writers who attempt to generalize about a problem which really involves analysis of specific facts and circumstances. I'd like to try in the time that I have to discuss some of those facts and circumstances which would be taken into consideration in deciding whether or not to incorporate your practice. Then I'd like to discuss some of the requirements for the proper operation

of a professional corporation so that you can avoid some of the pitfalls which you may experience if you're not careful.

First of all, it would certainly be foolish for anyone to incorporate their practice and thereby cause additional problems. It should be established and operated so as to run more or less automatically. It will take some initial adjustments to get the corporation established, but you should be able to get into the routine of practicing your profession in the corporate form quickly.

The primary objective of a professional corporation is to obtain the same tax shelter benefits that the executives of large corporations get--retirement plans or deferred compensation--which really are not available to professionals in a similar degree unless they incorporate. A qualified retirement plan is really a form of a savings program. It's a system whereby you save part of the money you earn from your practice each year. The benefit of a qualified plan is that you can make the savings before paying taxes on the money. You get a deferral on your tax bill. There are in many cases great advantages to being able to defer the payment of the tax because you are able to contribute money to a qualified pension or profit-sharing plan, take a tax deduction for it, and use the government's money to build up a fund over 15, 20, or 30 years. At the end, you'll have a great deal more than you would have if you had put your money in savings or investment after paying tax on it. Certainly, the kind of savings program we're talking about here should be approached as a conservative investment, however. This is not going to be like an oil well in Texas. This should be viewed as something that you're going to have when you get to be 65, 70, or 80 years old.

One of the basic considerations in deciding whether to incorporate is whether you will be able to save any money after incorporation. The establishment of a qualified corporate retirement plan is not going to enable you to have more money to spend. Unless you have been saving some part of your earnings, you will have to reduce spendable income with incorporation. On the other hand, if you're in the 50 percent tax bracket, which for joint taxpayers starts at about \$44,000 of taxable income, and you incorporate, anything that you put into a qualified retirement plan--or anything that you put into a Keogh plan if you don't incorporate--is money that you would otherwise have had to pay 50 percent of to the government. So even though you have to reduce your spending somewhat to build up a savings program, you only have to reduce it by one half of what you're able to save.

The decision to incorporate would also involve analysis by each of you of your personal living habits. How much money do you have available to set aside? Can you change your habits and be able to save money? Can your wife or husband change her or his habits and be able to save money? How much money are you going to have to spend in the next few years for the college education of children? If you are 45 or 50 years old and you have six kids in college, then incorporation is probably not for you at this time. If you have elderly parents whom you're



obligated to support, then again a professional corporation possibly should be postponed, depending on your other financial circumstances.

We have a general rule of thumb that a professional should not incorporate unless the net income from his practice is at least \$50,000 or maybe even \$60,000 to \$70,000. You know that you can contribute 15 percent of your taxable income or self-employment earnings to a Keogh Plan with a maximum contribution of \$7500. At \$50,000 the 15 percent mark is \$7500, and that's how I get to the breaking point.

It is possible in a professional corporation to gain additional tax deductions that are not available to the unincorporated. Those tax deductions, aside from the qualified retirement plans, include disability insurance and medical and dental care expenses, medical care expenses to an individual, but only if they exceed 3 percent of his adjusted gross income. In most cases the medical expenses are less than that, but they are still very real. If you have a corporation, you can deduct medical expenses from dollar one, in effect, and not be affected by the 3 percent limitations.

There's a certain type of life insurance which your corporation can buy, the premiums for which it can deduct. This special insurance is group-term life insurance under section 79 of the Internal Revenue Code, for which an individual would normally get no tax deduction.

There is some discussion of the idea that if you're not able to save much money now, then incorporate. Go to all the trouble to get the lawyer, the insurance man, and the bank trust officer involved and get yourself obligated to a larger number of people. Then when you get all this paper structure set up, you will then be forced to save money that you otherwise wouldn't save. I have always been skeptical of that approach. I know a lot of life insurance has been sold on that basis, but I would think that a professional should be able to control and not need the prodding of the forced savings concept.

There are still some advantages to a corporate retirement plan over a Keogh plan which requires no incorporation. The limitation on contributions to a Keogh plan has been raised from 10 percent of earnings or \$2500 to 15 percent of earnings or \$7500. However, if you're able to save more than \$7500 in a year, then incorporation should be looked into, because with qualified defined benefit corporate plans, you can put aside 25 percent of your earnings or \$26,825, whichever is less.

Many of the articles which I mentioned had condemned corporate plans focused on taxes. If you have the Keogh plan, you have a much smaller plan; therefore, when you take the money out in a lump sum, your taxes will be less than with a corporate plan. In these articles, it always comes out that in the corporate plan you wind up with more money in hand, but not as much as the initial sum that you build up would indicate. However, those articles and that approach make many assumptions as to when the money is going to be taken out, how it's going to be taken down, and how that money that's not put into the corporate retirement plan

is going to be kept after taxes and invested in some other form of tax-exempt investment such as municipal bonds. I'm not at all sure that it's good to be forced to invest in tax-exempt municipal bonds, especially with the experience in New York.

There are still some differences in the eligibility requirements between the Keogh and the corporate plans. In Keogh you must include all employees who have 3 years of service with your partnership or sole proprietorship. If you have a corporate plan, you can exclude employees until they reach age 25. A person who's reached age 25 must come in after at least 1 year of service, however.

The treatment of Social Security is also different in the two plans. It's impractical to integrate a Keogh plan with Social Security. You could do so, but two-thirds of the contributions of the plan must be allocated among the lower paid employees. A sole practitioner or partnership certainly would not want to establish a plan in which two-thirds of the contributions of the plan are allocated to lower paid employees. Integration of Social Security into the corporate plan, on the other hand, means that you contribute from 5 to 7 percent less on the compensation of lower paid employees as you do for yourself. You could put a full 25 percent away for yourself and maybe only 18 or 19 percent for lower paid employees. It reduces your costs.

The federal estate tax exclusion for distributions from a qualified retirement plan established by a corporation is still available, but there is no such exclusion for distribution from a Keogh plan.\* This also applies to the Kentucky inheritance tax. There is no justification that I can see for this difference. It can mean a significant savings, because while the estate tax rate is only at 3 percent above \$60,000, it can go all the way up to 77 percent on \$10,000,000. On an average estate for professionals, which might be between \$100,000 and \$250,000, the federal estate tax rate is 30 percent.

There are, of course, no loans permitted from the Keogh plan, but with a corporate profit-sharing plan it is possible for a participant to borrow money from it in cases of unusual need or emergency. There's a lot of question as to what an unusual need or emergency is, but we have taken the position that unusual medical expenses would be a justification for borrowing money from the plan. If education expenses come along for children in college, and there's no other way to get the money, it could be borrowed from your corporate profit-sharing plan.

The retirement plans and the entire corporate arrangement should be as flexible as possible since we don't know what the future holds for us. That's not possible with the Keogh plan. No distributions can be made from the Keogh plan

---

\*This distribution was eliminated by section 2009(c) of the Tax Reform Act of 1976. Effective January 1, 1977, amounts receivable from a corporate or Keogh plan and paid in a manner other than lump-sum will be excluded from the decedent-participant's estate. An annuity or installments over a period of at least 36 months are methods of distribution qualifying for the exclusion.

without paying a penalty tax until 6 months before the professional reaches age 60. On the other hand, distributions must begin 6 months before the professional reaches age 71. Those required distribution times do not apply in a qualified corporate plan.

A Keogh plan is also less flexible in that if it covers an owner-employee--that's an employee who owns at least 10 percent of the stock or a 10 percent interest in the partnership or is sole proprietor--then even a profit-sharing plan must provide a definite contribution formula, IRC §401(d)(2)(B). In other words, you must agree to contribute a fixed amount each year. That's not true with a corporate profit-sharing plan. If you have a bad year, or if you've taken 6 months off to go to Europe and you don't have money to put into the corporate profit-sharing plan, you can skip the contribution for that year without affecting the status of your plan at all. Contributions to corporate profit-sharing plans are completely flexible. You can put nothing in each year or you can contribute up to 15 percent of your compensation in each year. That flexibility always seems to be one of the advantages of a professional corporate plan.

There also remains an unusual difference in the voluntary contributions that can be made to a corporate plan as compared to a Keogh plan. If you should be fortunate enough, after you have put money into the retirement plans to the full extent, to still have money around to invest, you can make voluntary contributions to both a Keogh and a corporate plan. There are no current deductions on those contributions, but the earnings on those contributions will be tax-free until you take them out at the end. However, voluntary contributions to a Keogh plan are limited to \$2500 per year. The limitation on voluntary contributions to a corporate plan is an amount equal to 10 percent of compensation received during all years of participation. But keep in the back of your mind that the voluntary contributions you make to a corporate plan, after the Tax Reform Act, will count as annual additions to the plan to the extent that they exceed 6 percent of your compensation for the year. But that still can very often be more than \$2500 dollars.

There are other fringe benefit plans which a professional corporation can adopt other than the qualified retirement plan. You're not going to get a tremendous amount of tax savings from those other plans, like the medical expense plan or the deductions for disability insurance or the group term life insurance plan. If a sole proprietor incorporated and the tax savings from all these plans put together was \$500 or \$1000, that would be unusually good. The big tax saving comes from the qualified retirement plan.

There are some non-tax considerations to incorporation of your practice. One is that there are some limitations on liability. Under most state laws and the common law, you are liable for the acts of your partner to the full extent of your personal assets if you are not incorporated. If you have a corporation, that joint liability ends. If a shareholder of a professional corporation commits malpractice, of course, he's liable to the full extent of his assets under the

state laws, but the other shareholders in the corporation are not liable. The corporation itself would have liability, but in most cases we try to keep the assets of the corporation small so that if the liability should ever happen to attach, not much would be lost.

There are some organizational advantages to incorporation. It can aid efficiency to get defined lines of authority--to have a board of directors, a president, a treasurer. There are some advantages to operating in the corporate form just because it gives a certainty of form of operation.

Another advantage which I'm not so sure about is that young doctors may feel very impressed when they find that the persons who may hire them have incorporated their practice and have all of these retirement plans and fringe benefit programs established. It makes you look a lot more like you have the latest in the practice of medicine or law.

There are some aspects that you've probably heard about that I don't feel are beneficial to the corporation. One of those is the ownership of an automobile by the corporation. It can be actually a detriment. If there's more than one doctor, and one drives a Volkswagen and the other drives a Mercedes Benz, you may have a cause for friction right there if the corporation owns both those autos. Additionally, the ownership of automobiles by a professional corporation can cause a tax problem. If the Internal Revenue Service audits the corporation and decides that the automobile is not entirely for use in the business, it will treat the use of the automobile by the doctor as a dividend and deny a deduction to the corporation. The result is that the corporation pays tax on the disallowed deduction at the corporate tax rate, which is 20 percent, and then the doctor pays a tax on the use of the automobile at his normal, personal individual tax rate as a dividend. If the doctor owned the auto and claimed the deduction on his individual return, there would not be the double tax risk.

There's another advantage which I want to talk about. In many cases a doctor or lawyer will own his own office building. One way to avoid paying taxes on it is to transfer the rents from your office building to your children in trust. The courts have uniformly held that this is a sham transaction, and that the rentals are not proper business deductions. However, if you have a corporation which is operated properly, that gives you a legitimate business reason to pay rent, because your corporation must pay rent since it is a separate legal entity from the doctor or lawyer. That rent should be and will be deductible by the corporation when the payments go from the corporation to the trust. The income in the trust can be accumulated for the benefit of the children to pay for their education. The rent payments as they are earned by the trust will be subject to tax from either the trust or the child, if the distribution is made from the trust for his benefit.

There are some problems to watch for in this situation. If the trust pays any of the support obligations of the parent, then the parent will have to pay income tax on such amounts that go into the trust. The way to alleviate that problem is simply to have the trustee accumulate the money in the trust for the

benefit of the children to pay for their education. The rent payments as they are earned by the trust will be subject to tax from either the trust or the child, if the distribution is made from the trust for his benefit.

There are some problems to watch for in this situation. If the trust pays any of the support obligations of the parent, then the parent will have to pay income tax on such amounts that go into the trust. The way to alleviate that problem is simply to have the trustee accumulate the money in the trust for the benefit of the children and not pay it out to them until they reach age 18, when the legal support obligation ceases. This just happens to be at about the time that they're going into college, when the big expenses come.

#### QUESTIONS AND ANSWERS

QUESTION: Did you say that with the Keogh plan, you must make a contribution every year once you've established the plan?

MR. RICH: Yes, if you're a sole proprietor or if you're a 10 percent partner or more. Furthermore, you can't vary the amount of percentage that you pay.

QUESTION: In a corporation, how do you go about determining salaries? We have a partnership in our law firm, but we have wide ranges of income. It appears to me that the form of written contracts for the distribution of income varies in proportion to the amount that was earned. If one partner, because of his productivity or efficiency, makes more money and puts more accounts receivable on the books of the corporation, those differences could be reflected in the compensation formula that a corporation adopts, just as it can be done with a partnership.

It is, of course, a question with a corporation as to whether compensation paid by it is deductible. Should the professional corporation pay dividends? We feel that it should. The dividends should be based on the capital investment that the former partners--now shareholders--have made in the corporation. There are two cases dealing with this subject: McCandless Tile Service, 422 F.2d 1336 (Ct. Cl., 1970), and Barton-Gillet Co., 29 TCM 679 (1970), which were both bad cases for the taxpayers and good cases for the Internal Revenue Service. We advise most of our professional corporations to pay out some dividends because the brunt of the argument is that there should be some return on invested capital to the shareholders. Of course, you can cite many cases of corporations that don't pay dividends--American Airlines doesn't pay dividends and they have a lot of capital--but in your planning you should attempt to head off the problem by paying a dividend to help counter the unreasonable compensation argument.

We have many cases--and none have been successfully challenged--where compensation is based on productivity. It was a wonderful thing to have during the wage-price freeze. Many advisors at that time said that you couldn't raise salaries because of the wage-freeze portion of the Economic Stabilization Act, but with a formula for compensation you weren't subject to that. So that's some more flexibility that you might consider with regard to professional corporations.

QUESTION: If all partners receive completely equal compensation after a term of indenture, could the corporation be worked so that the wage-price freeze would not adversely affect that situation?

MR. RICH: Yes. Again, I would suggest that a clause in the compensation section of your employment contract--and it's very important to have an employment contract--state that the intention is to distribute to professional employee Doctor X an amount in total compensation that's equal to the billing that he has generated. We had no particular problems with sustaining increases in compensation which were caused by an increase in productivity and efficiency, so long as the corporation had not raised its fees for professional services.

To return to the body of the lecture, you should be aware that there are a lot of beginning expenses, including attorney's fees, filing fees, additional fees to your accountant, fees for expenses in changing your signs, billhead, phone listings, and things of that sort. We would judge that for a one-man corporation, those expenses might be as much as \$2,000 or \$3,000. Basically that's a one-shot charge just to get the corporation set up. There are some annual recurring expenses which you'll also want to consider. There will be extra expenses because of legal and accounting fees, and if you have a paid trustee, you'll have trustee's fees. Those totals shouldn't amount to more than \$200 or \$300. If you have a defined benefit plan, you'll have to hire an actuary. They charge anywhere from \$500 to \$1,000 a year for making the computation necessary to calculate the contributions of the plan.

One of the big costs of incorporating arises from the need to include other employees in the plan. If you have a Keogh plan, of course, you're already doing that. By having a corporate plan you can lessen the cost of including the other employees by taking advantage of integration with Social Security and by providing in the plan for deferred vesting, which I didn't mention, but which you can't have in the Keogh plan.

There are additional costs for Social Security coverage. You'll have to cover yourself if you're in a corporation, and so, of course, you'll have to pay Social Security tax on yourself and an employee. However, the difference is not very great between the self-employed person rate, which is 7.9 percent, and the joint rate for the corporation and the employee. Since the employer's portion of the Social Security tax is also a tax deduction, the effective rates which you should compare are 7.9 percent for the self-employed rate compared with 8.7 or 8.8 if you have a corporation and pay the tax both on yourself and on the corporation.

In Indiana there is a gross income tax which increases the costs of operating as a corporation. There's no way to avoid that. In most cases, we attempt to have our corporate client pay out most of its earnings in some tax-deductible form, either in the form of compensation to the professionals or contributions to qualified plans or, if necessary, a bonus to the professionals. Then there is a small dividend each year. But in Indiana with its gross income tax there is a cost of a little over 1 percent.

There are some formalities of corporate operation. There are only two cases which the Internal Revenue Service has won in challenging corporate status. Of

course the IRS picks good cases to litigate. One was the Roubik case, 53 T.C. 365 (1969), which was decided in the Tax Court. That was the case where four radiologists incorporated and then proceeded in all respects to act as though they had no corporation. The individuals in the corporation received payments from hospital personally and then endorsed the checks over to the corporation. They didn't hold themselves out to the public as a corporation. The hospitals weren't even informed that these four radiologists had incorporated. They worked at four different hospitals, and there was very little interchange of work among them. There was really no unity of operation. One of the doctors continued to participate as a partner in another professional venture. He received money outside the corporation framework from that work, but that was professional practice income. Each doctor had a contract in his individual name with the hospital at which he performed services. If you're going to have a professional corporation, your contracts and formal legal documents should be in the corporate name.

Each of the individual doctors supervised his own personnel. There wasn't any corporate management. They sent bills out in their individual names. It was just a horrendous case, a case that the government had to win. The case tells you the minimum things you should do to act like a corporation. If you aren't careful, the status of your corporation is in jeopardy. You really don't lose a great deal, but you don't gain the benefits of incorporation either.

There are some professional management consultants around who will advise you that in order to eliminate the cost of including other employees in a qualified corporate plan, you should have all of your employees put on the management consultant firm's payroll. That's flying right in the face of the ruling in Roubik. That corporation didn't own any equipment; it didn't hire anyone except the doctors.

If you're going to have a legitimate professional corporation, it must perform some business function. You should use the corporate name in your advertising and your phone listing. You should list it on your stationery; it should be on your bills, your contracts, your insurance policies, and your checks. If you're going to make a good case for establishing the separate existence of your corporation, you shouldn't be ashamed to use your corporate name.

The other case that was lost by a professional corporation had the same sort of ridiculous facts. Epperson v. U.S., 74-1 USTC ¶9284.

Some of the other formal requirements, such as articles of incorporation, by-laws and officers, are fairly standard things. One danger for lawyers, and you should be careful with this, is treating a professional corporation just the same as any other corporation. You shouldn't. They're different. They're different because they're a strictly personal service corporation. There is a set of different principles that apply, and you should be careful to recognize those.

As I told you, the employment contract is a key document. There should be a clause in the employment contract to the effect that the doctor-employee is

devoting his exclusive services and loyalty to the corporation. In a one-man corporation, it is a very self-serving document, but it still should be there. It's important that these trappings be present, but they shouldn't be burdensome to you. They should become automatic.

You might also add to your employment contract provisions that the corporation expects the employees to have an automobile available for use, to subscribe to professional publications, and to attend meetings like this one in order to continue their professional education. By having that in the employment contract as a requirement of employment, it gives the doctor whose tax return is audited after he takes deductions for his trip to Bermuda for a conference, or to Lexington, Kentucky for a conference, or to Cincinnati, Ohio for a conference, something to point to in saying that the expenses were required by his employer, the professional service corporation.

It's fallacious to assume that having the corporation automatically legitimizes deductions for trips and conventions which are not really exclusively for business. If you're going to go on such trips and take such deductions, it's better that you do it on your personal return, not on the corporation's return, because of the double-tax problem I mentioned earlier in connection with automobiles.

I won't go into some of the technical tax questions that I allude to in my outline about how to transfer your assets from your individual practice to the corporation. One thing to keep in mind in so doing is that it should be a tax-free transfer. You should transfer accounts receivable to the corporation; it pays the taxes on them as it collects them.

You should not transfer liabilities in excess of the value of the assets that you transfer. That would trigger a tax on you personally. In other words, if in your practice you borrow money, and you incorporate and transfer assets worth \$1,000 plus loan obligations worth \$2,000, then you individually as a result of that transfer have received, as far as the tax people are concerned, \$1,000 worth of boot. That means that you have to pay tax on that \$1,000 net difference. So make sure in your transfer to the professional corporation that the assets always exceed the liabilities. If necessary, keep the liabilities in your own name and pay them off personally rather than transfer them to the corporation.

I mentioned the dividend question. I told you that you could pay out on the basis of a formula. It's very important that you consider this and that you have a basis for the formula. However, I'm not as worried about the unreasonable compensation problem as other people are. We've had no bad experience with putting the compensation formula in employment contracts. I think it should be done.

Now let's talk about qualified retirement plans, pension plans, and profit-sharing plans. If you're going to have just one plan, we recommend that you have a profit-sharing plan because it's the most most flexible. You don't have to contribute anything to it if you don't want to; you can put in up to 15 percent of the compensation paid to participants.



If you can save more than 15 percent, then you should consider using a money purchase pension plan too. That's just like a profit-sharing plan in that it doesn't guarantee any fixed benefit. However, it enables you to contribute an additional 10 percent.

There may be advantages to very high income physicians in a defined benefit pension plan. A defined benefit plan is a kind of plan that provides a guaranteed monthly or annual income after you reach retirement age. You can put more money into a plan like that than you can with the two plans I've mentioned because it's a fixed end-benefit plan. The maximum benefit under the new law, with the inflation adjustment is now \$80,475 a year. To find out how much you have to contribute in order to get that end benefit, you go to an actuary. He makes some calculations and assumptions and tells you how much you must put in each year. The amount that you put into such a plan is currently deductible to you or your professional corporation.

I've done some rough calculations on this. If you're age 40, that means you have 25 years until you're 65. You could put \$13,988 a year into it to fund an end benefit of \$80,000. That assumes a 5 percent growth rate, a 5 percent interest rate, and that you pay in the same amount each year. It's called a level annual premium. If you're age 50, you would contribute, and deduct, \$30,000 a year. But then you're talking about well over \$100,000 in compensation to fund such a plan.

You might be satisfied with a \$26,825 limitation on annual contributions to your account in defined contribution plans. If you find that uncomfortable to live with, take a higher tax deduction than the \$26,825 limit, you can do so by adding a defined benefit plan.

That's because there's a special 140 percent rule for computing the limitations on benefits when defined benefit and defined contribution plans are combined. For example, assume you have a defined contribution plan like profit-sharing, and fund that to the maximum percent, putting \$26,825 into it. That would require income of \$178,000. But after you put the 15 percent into that plan, you're entitled to have a separate defined-benefit plan, which will provide a maximum benefit of 40 percent of the benefit otherwise allowed by the law for defined benefit plans. The maximum plan is \$80,000 and 40 percent of that is \$32,000. To fund that, if you're age 55, costs \$21,000 a year. So instead of being limited to the \$26,000 limit that the new pension law provides, a doctor in that situation can put aside \$47,000 (subject to the overall 25 percent deduction limit). This is not for the average earner. This is certainly for the physician or lawyer with earnings of more than \$150,000 per year.

I think you should look into integrating any retirement plan you have as this can cut down the cost of including other employees. If you have two plans, you can only integrate one. Keep that in mind. You should also consider deferred vesting in all plans. The basic rule for small professional corporations is that you must have 100 percent vesting after 10 years of participation in the plan or 10 years of service with the corporation. The Internal Revenue Service is currently taking the position that an employee must have a vested interest of

40 percent in your plan after four years of service. That interpretation is subject to challenge. If you do have deferred vesting in your plan, it encourages an employee to stay longer, which is what you want. It also has the benefit that if they don't stay as long as you want them to, the benefit of their forfeitures will partly go to you. In a profit-sharing plan, the forfeitures are reallocated among the accounts of the existing participants on the basis of the relative sizes of their accounts, which means you would get most of them into your account. If it's a pension plan, the forfeiture is used to reduce the next year's contributions to the plan.

One thing I wanted to mention is insurance in a qualified plan. You will be besieged, if you haven't already been if you've incorporated, by insurance men who encourage you to invest part of your plan assets in insurance. They will assure you that the tax laws permit 50 percent of your plan assets to be invested in insurance. I personally have doubts as to whether insurance is a good investment in a plan. If you need the death benefit protection, then possibly you should consider it. But just as a pure investment, insurance can usually be beat with some other form of investment. Even a savings and loan investment is better. So you should look very carefully at it.

I'm not sure whether you know this or not, but if you do invest in life insurance in a qualified retirement plan, a portion of what goes into the plan is taxed to the individual on whose life the insurance is purchased. By buying insurance in a qualified plan, it actually detracts from the tax savings that would otherwise be available.

If you have a Keogh plan, the best advice as to what to do with it if you incorporate is to freeze it. It is possible to have it transferred, but in my opinion is more trouble than it's worth. The only advantage you gain is having all your eggs in one basket, with the same trustee investing both funds. The Keogh rules and restrictions continue to apply to the Keogh funds in any case.

QUESTION: How do you go about getting your plan approved by the Internal Revenue Service?

MR. RICH: I'm glad you mentioned that. I've run into some cases where people have not submitted plans to the Internal Revenue Service for qualification determination. That should be a standard step. You do that after you adopt your plan. It will be submitted to Louisville if you're in Kentucky. In Indiana it goes to the Indianapolis office. In Ohio it goes to the Cincinnati office or the Cleveland office. You send along forms which give summary descriptions of the plan, and then the Internal Revenue Service works with you in changing your plan, if necessary, to make it conform to their latest requirements. They have special requirements for professional corporations. Just because you have a plan that satisfies the guidelines of the law doesn't mean that it will be approved. For instance, if it's a professional corporation, the IRS doesn't accept a very long vesting term. It doesn't like a 10-year vesting period. It prefers percentage vesting as each

year passes. For a vesting schedule to be approved, it must not discriminate in favor of higher-paid employees. Usually this is just a formal matter. You submit the plan to the IRS and they readily approve it.

QUESTION: If you want to know more about this subject, is there a place that you can take short course on pension law or professional service corporations or whatever?

MR. RICH: Yes. It seems like or there have been, in the past at least, a lot of conferences like this where the whole program is devoted to professional service corporations. Maybe you could have one here, John.

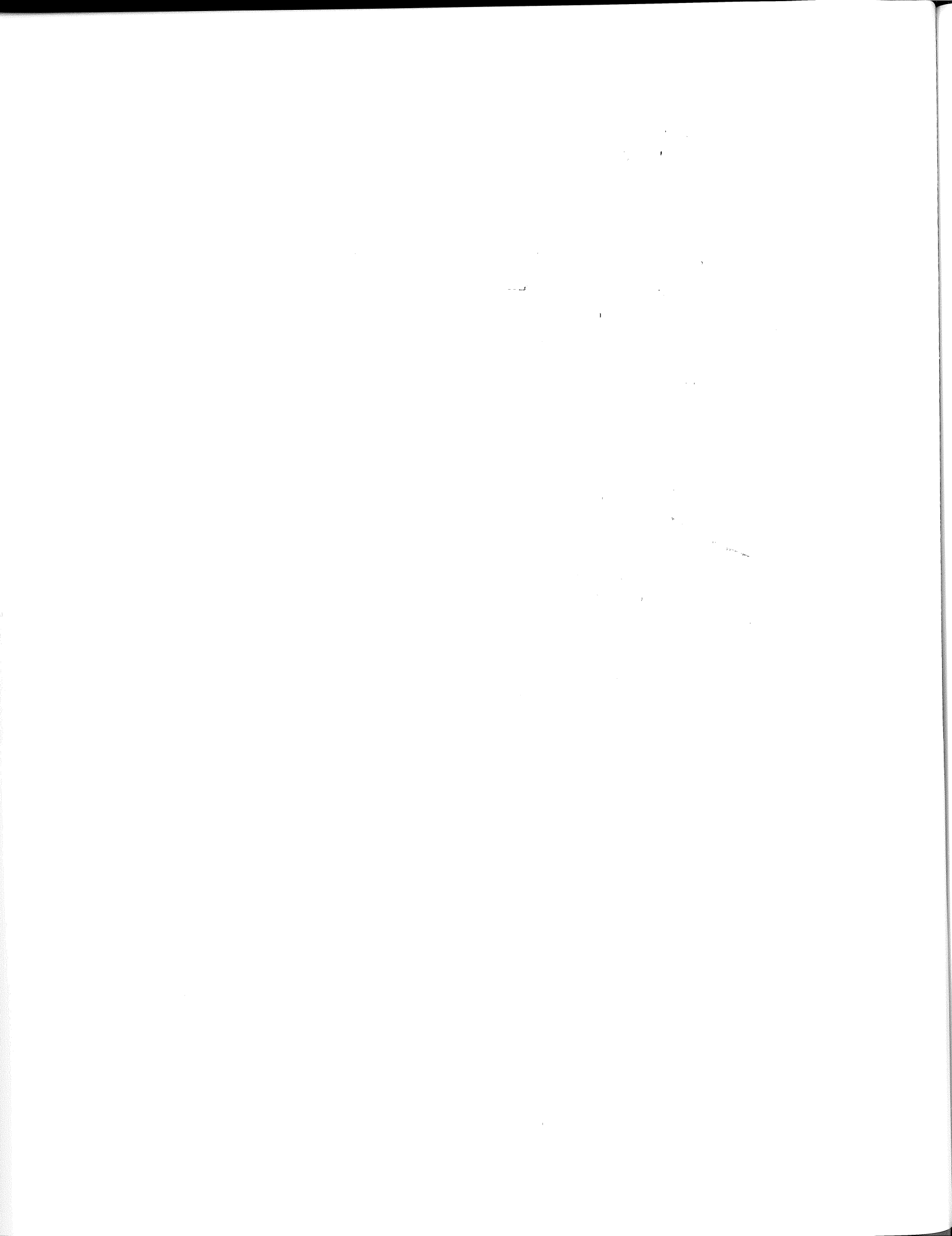
MR. HICKEY: We had a day-and-a-half program on the Pension Reform Act when it first came out. There are quite a few by the American Bar Association, the American Law Institute, and other national groups on this currently. I don't know of any local ones that are immediately available.

MR. RICH: But there are people around who specialize in professional corporations. Maybe you could just bend their ear for a while.

MR. HICKEY: I think Professor Whiteside has a comment on something you just said.

MR. WHITESIDE: Will a plan go through the IRS for approval as easily where a practitioner makes himself the trustee of his own plan?

MR. RICH: There should be no problem to obtain qualification determination from IRS if the professional is his own trustee. There are some legal questions. If the doctor is trustee and he's also on the advisory committee and he's also the only beneficiary, then we have the doctrine of merger of trust estates which could apply. The IRS has raised that question to our firm. We wrote a legal memorandum in reply, telling them why the doctrine of merger doesn't apply. It is a technical legal question, and if for some reason there are not other beneficiaries beside the doctor, he should have his wife or a bank as trustee along with him. In most cases during the early years, a doctor could serve as trustee himself. But when the funds get to be in amounts which you need professional advice on how to invest and you don't have time to do it yourself, you might as well go to a professional trustee like a bank.



## ESTATE PLANNING FOR THE PROFESSIONAL<sup>1</sup>

Edward A. Rothschild, J.D.  
Washer, Kaplan, Rothschild,  
Aberson, Miller & Dodd  
Louisville, Kentucky

I'm going to talk to you about a subject in which you do not have an election like you do in choosing a professional service corporation. I'm going to talk to you about a subject which is as sure to happen to you as you are sitting in this room, because I'm going to talk to you about death and taxes. I'm going to break this into two parts. First, we shall discuss what your estate consists of and what the death taxes based on your estate consist of. Second, we shall discuss tax planning and economic planning for your family. In this lecture, I'm also going to talk about some major misconceptions that some doctors and lawyers have when it comes to estate planning. I am going to discuss estate planning for professionals like you, but much of what I'm going to say applies to other types of professionals as well as businessmen.

One basic point about estate planning is that it is very similar to fingerprints in that there are no two alike. What you own is probably not going to be similar to what the man sitting next to you owns. Your individual family situation is going to be different from the family situation of your neighbor.

Let's first talk about what your estate consists of. What's included in your taxable estate for death tax purposes? The first item I usually think of in this area--and one of the most elective items--is life insurance. Life insurance should normally be one of the major assets in your estate. Why? Because over the years of our practice, in trying to increase the standard of living for ourselves and our family, it's important for us to take stock of what will happen to this standard of living upon our death. Life insurance gives immediate large benefits in the event we die.

Let me talk to you about a problem that I see in many estates. In 24 of 25 estate plans that I get involved in, I find it necessary to change the beneficiary of the life insurance policy. Think about your life insurance and about who the beneficiary is in your life insurance policy. If you're fairly typical of most people who take out life insurance, your wife is probably the primary beneficiary and your children are the secondary beneficiaries or maybe you don't even have a secondary beneficiary. Well, let me tell you about one important salient fact. Life insurance does not pass by will; it passes by contract. It doesn't make any difference what you state in that will. You can have a great marital deduction trust and a great residuary trust protecting your children until they become 25 or 30, but if you don't change the beneficiary of the life insurance policies, those funds are going to be taxable and they're going to be distributed in accor-

---

<sup>1</sup>This lecture was given before the passage of the Tax Reform Act of 1976 and does not cover the changes reflected in that Act.

dance with that contract. So as a general practice, I effect the changes of beneficiaries to tie in with what the client wants in his will.

Now let's talk about taxability of life insurance, because this involves another great misconception. You have to take into consideration the two basic death tax laws--the federal estate and state inheritance tax laws. Life insurance proceeds paid at death are fully taxable for federal estate tax purposes if the decedent owned the policy at his death. Ownership rights of a life insurance policy cover a number of rights, such as the right to change beneficiary, the right to borrow on the policy, and the right to pledge the policy as security. In Kentucky, life insurance left to a named beneficiary, to a testamentary trust, or to an inter vivos trust is nontaxable even though the decedent kept the ownership rights. But if the estate is the beneficiary of a life insurance policy, it's fully taxable in Kentucky for Kentucky inheritance tax purposes.

I'm not going to talk any more about qualified plans, because that was well covered by the previous speaker, but I do want to emphasize one thing about the qualified plan beneficiary. If you are incorporated and have a qualified plan, and if it's left to a named beneficiary, there are no federal estate taxes on it.<sup>2</sup> However, if it's left to your estate, it is fully taxable for federal estate tax purposes.

Now let me talk to you about another misconception; that's how title to real estate should be held. Real estate and personal property in joint survivorship are treated differently for federal estate tax purposes than for Kentucky inheritance tax purposes. For federal estate tax purposes, if you have a piece of property in joint survivorship with your wife or anyone else, the full value of that real estate will be taxed upon your death in your estate, unless the other party can prove that he or she made an economic contribution to that property. That fact sometimes is very difficult to prove. It's very difficult to explain to a widow that she does not have any legal interest that we can keep out of her husband's estate because she didn't make any financial contribution to it, when she might have raised the kids and done all the housework. Therefore, I quite often find that joint survivorship is one of the worst ways for property to be held. I normally make an exception to this rule when it comes to the home because joint survivorship of a home allows the wife to get the residence immediately upon your death. Remember that joint survivorship property does not pass by will.

Let me tell you about a case I had about 5 years ago to illustrate the dangers of joint survivorship property. I had a client who came in for some estate planning. The first two things I discuss with all my clients are about

---

<sup>2</sup>Since my talk, the Tax Reform Act of 1976 now states that a lump sum distribution from a qualified plan is taxable for federal estate tax purposes regardless of who is the beneficiary.

their family situation and what their estate consists of and how property is held. This man had been married previously and had three children, his wife had been married previously and also had three children, and they had one child together. It was my client's desire to provide first for his wife's financial security with his total estate to be divided equally among the seven children later. Then I got into the second phase of our conference. This gentleman had assets of \$1,600,000. All but \$100,000 was in real estate. My next question to him was how was the title to the real estate held. He answered that all his real estate was in joint survivorship with his wife. I told him I could write a will with a marital deduction and set it up in a trust that would eventually pass half of the property to his seven children. But then I said that nothing would pass by his will because joint survivorship means it's immediately going to pass to your wife when you die. I explained that if she dies one minute after you do and doesn't have a will, the three children by your prior marriage--under Kentucky law--are going to get nothing because her property will go by descent and distribution to the children by her previous marriage and to your one child. Then I presented the following additional contingencies. Let's say that a few years later your widow gets married and decides the best way for all the real estate to be held is in joint survivorship with her new husband. Then she dies. Her second husband might end up with \$1,500,000 worth of property less taxes, and all seven children could be left out in the cold. Believe me, at this point in the conversation, he's beginning to squirm. As another example, if your wife should decide later that she wants to leave the real estate differently from how you stated you wanted it in your will, all of the real estate will be left as she desires.

Then I said, let's say that she leaves all of this property to the seven children in equal shares, with a similar trust as you will establish in your will and thus she carries out your wishes on all of the property that she's inherited from you. Your seven children are going to receive approximately \$225,000 less and the taxing authorities are going to receive that much more because you overfunded the marital deduction. In all probability, all the property you leave at your death is going to be taxed again at your wife's death. Now in joint survivorship real property between husband and wife, there is an escape valve for gift tax purposes. If the spouse contributed solely to the purchase of the property, you can transfer that portion back into the spouse's sole name without any gift tax consequences. Serious consideration should be given when you buy property to determine how the title to the property is to be held, and normally joint survivorship is not the best method to take title.

Next, I would like to discuss with you professional partnerships and professional corporations. What provision have you made for getting some funds out of this corporation as compensation, for example, for past services? What value do you have on that stock or on that partnership interest? Who's in the position to best determine what the value of your stock in the corporation or your partner-

ship interest is? It's you! When you're healthy and your partners are healthy or your fellow stockholders are healthy, you can work out a reasonable agreement at arms length to protect the value of your interest as far as your estate is concerned.

If you own coin collections, stamp collections or other similar type property of value, take special care of them. If you are the executor or the attorney for an estate that has this type of property, you should put them in a safety deposit box immediately because they're like cash. These type properties are hard to evaluate and usually require the use of experts. Sometimes it is necessary, where the value of the collection is high, to get experts from New York, Chicago, or Los Angeles who will come in and appraise and sometimes buy them.

Everything you own is included in your estate. I've found that in 96 of 100 cases, when my client sits down and takes a financial inventory of his estate, including face value of life insurance and fair market value of his real estate, he is surprised at the total value of his estate. If you haven't taken such an inventory, you should; it's later than you think. Anyone with an estate greater than \$60,000 has an estate tax problem. Federal estate taxes affect everyone in this room.

With the federal death tax you start off with the gross estate, which is the fair market value of everything you own. If you have real estate, don't think of it in terms of what you paid for it. Think of it in terms of what it's worth now because the taxing authorities will, and it can make a tremendous difference. You subtract from that the funeral expenses, debts, administrative expenses, mortgages, and that leaves you with an adjusted gross estate. You can leave one-half of the adjusted gross estate to your spouse tax-free. Charitable bequests or devises are also completely deductible. These can be made in specific bequests to your church or other charity, or you can do it in such a way that the charitable institution gets the remainder interest of a trust. But if you do it the latter way, remember that there are only three ways under the law to do it. You must either have a uni-trust, annuity trust, or pooled income trust. If there is an individual that you want to have the benefits of a trust for his or her lifetime and then leave the balance to a charity, you should work it out in accordance with one of the three above type trusts or you're not going to get the estate tax deduction for the remainder interest.

Every estate has a \$60,000 exemption. After that's taken off, you've arrived at the net taxable part of your estate. The rates on this start off very low. On \$100,000, you take out \$4,800; on \$200,000, you take out over \$31,000; on \$500,000 you take out over \$100,000 and on \$1,000,000 you take out almost \$300,000.

There are a couple of instances where, if you have a closely-held corporation or real hardship situation, it can be paid over a period of years, but the interest is 7 percent. Two years ago when it was 4 percent, we were using this installment pay method whenever available.



There are federal tax credits that you lawyers particularly want to remember. You automatically get credit for part of the state inheritance taxes up to a certain percentage which is contained on a chart. In most states, with the exception of Florida, the state death taxes are usually considerably higher than the credit you get for the federal death tax.

It is important to analyze whether your client had received any proceeds from another estate within the last 10 years. You might have a credit against the tax for part of the estate previously taxed. Gifts on which gift taxes were paid might get you a credit for that gift tax if the property gifted is brought back into the estate.

The Kentucky inheritance tax is treated differently than federal death taxes. Most state inheritance taxes are based on the property received by and the relationship of the beneficiary to the decedent. Federal estate taxes are not changed by who gets it, with the exception of the marital deduction received tax free by the spouse. In Kentucky, a wife and minor children are in a different class; it means that they get larger exemptions and the tax rates are different. In Kentucky now either spouse gets a \$20,000 credit. Up until this change in the law, by the 1976 Legislature, a wife got \$10,000 credit, a husband \$5,000. Life insurance is treated differently in Kentucky and so is jointly owned property. Only one-half of jointly owned property is taxed in Kentucky, regardless of who contributed to the property. So you see, when you get into small estates, sometimes it's better to have joint survivorship property, but only with estates of less than \$100,000.

#### QUESTIONS AND ANSWERS

QUESTION: In the situation where a bank account is in a joint name between mother and daughter but the daughter didn't make any contribution to it, can the estate recover that money when the daughter takes it out of the bank?

MR. ROTHSCHILD: After the mother's death, the property automatically passes to the daughter. It doesn't pass through the executor; it passes outright to the joint owner. It would all be taxable in the mother's estate for federal estate tax purposes on the basis of your example, however.

QUESTION: Do you mean personal property and real property all pass at the same time?

MR. ROTHSCHILD: If it's in joint survivorship or if the bank account is on an "or" basis, yes sir. In Kentucky that's the law.

QUESTION: I presume from what you said that it makes no difference about the wording on a bank account--if there are two names, that indicates survivorship.

MR. ROTHSCHILD: If it's named in "or." In other words, just because someone has a right to withdraw funds from the bank account under power of attorney does not necessarily make it joint survivorship property.

QUESTION: In the example where the man had \$1,500,000 in real estate, if he and his present wife made a joint will that it go to the seven children, would that not be a contract which the wife could not break after his death?

MR. ROTHSCHILD: From his tax standpoint, that would be a disaster.

QUESTION: But from a legal consequence, would not the joint will be an unbreakable will?

MR. ROTHSCHILD: If it was a joint will, it does become a contract. However, if the property passed by deed, I don't think the contract would be applicable. The will would only apply to those assets that pass by that contract. If they agreed that all joint survivorship property had to be included in this contract--if they clarified it to that extent--then you might have a valid contract.

QUESTION: What would be the effect of a subsequent marriage on dower interest, assuming this contract exists?

MR. ROTHSCHILD: That's a good question. I'm not sure what the situation would be if the second husband came in and claimed his dower, or curtesy rights. What I emphasize to my clients in that kind of a situation is that it usually is not feasible to write a joint will. I stay away from them like the plague. The ones I've seen are disastrous.

QUESTION: Assume that it's not a \$1,500,000 estate but rather a \$50,000 estate. The husband wants to give the property entirely to the wife, and the only contribution she had really made has been raising the kids and maybe having a job at one time. Would there be any gift tax consequences on that transfer?

MR. ROTHSCHILD: Do you mean at death?

QUESTION: Well, at any time, would there be a gift tax consequence?

MR. ROTHSCHILD: Certainly in his lifetime, if he transferred real estate, he's made a gift.

QUESTION: Because she hasn't made a contribution?

MR. ROTHSCHILD: Yes, sir.

QUESTION: In other words, her raising the family and things like that would not be a contribution to the purchase price under gift tax law?

MR. ROTHSCHILD: No way. But under gift tax law they'd have some split gifts. You have a marital deduction in gift taxes as well as in estate taxes, but from the standpoint of a taxable gift, it would be considered as a gift for gift tax purposes. There's one exception to that. That is if at the time real property is first put in joint survivorship between husband and wife, if the parties agree that at that point they're going to treat it as if it's sold for \$100,000 and he gives her \$50,000, she'll receive no taxable gift. That's one option that you have when you put something in joint survivorship in real estate between spouses.

QUESTION: I've heard that Kentucky was the worst place in the country to die and leave anything. I wonder if you have an opinion on that from your experience. A related question is whether circumstances are so different in every state that if you construct a proper package for an individual in Kentucky, and he moves away, does he have to go through the whole thing all over again?

MR. ROTHSCHILD: There is no comparison, as an example, between the death taxes in California and those in Kentucky. California does not recognize the deduction of federal estate taxes on the California inheritance tax return. I have a California estate in which the federal death taxes were \$200,000. On the California inheri-

tance tax return we could not deduct it, and the California inheritance tax was almost \$100,000. Their rates are higher and they don't give you the exemptions that you get in Kentucky.

QUESTION: What about the question of moving from one state to the next? Are they so different that you almost have to totally revise the program?

MR. ROTHSCHILD: Not necessarily, but you should review it in any case. In Kentucky, life insurance left to named beneficiaries is not taxable, but this isn't true in a lot of states. Joint survivorship property? Check the state law. Kentucky doesn't care who contributed to the property. Joint survivorship property will be taxed at a 50 percent rate in Kentucky, unless given within 3 years of death.

I'm going to talk to you now about what I consider to be one of the most important tax shelters that exists and it's probably one of the cheapest. That is the proper preparation of a will. When you discuss a man's will with him, there are two things you should know before you even start discussing how he wants his property to be left. First, what is his family situation and second, what properties does he own? Often, you have to ask some personal and sometimes unpleasant questions in order to get to the facts. For instance, you start off with the basics. Is your wife healthy? How old are your children? Are they healthy? I wrote 16 or 18 wills last year where the clients had children with either a major mental or physical defect. When you start talking about that type of problem, you have to give serious consideration to setting up a trust under the will for the lifetime of the disabled child.

What properties become a part of the estate? First, you discuss life insurance beneficiary designations and how title to real estate is held. Then you're ready to start the progressive steps down through the will.

I normally have a separate specific bequest of furniture and personal effects primarily for more flexible income tax savings. As you know, at death you have a new income tax payer--the estate. Treat it with respect, because when you are writing a will, you should not only be planning the man's present estate, but also his estate post death planning as well. Specific bequests will not be considered a distribution of taxable income for fiduciary income tax purposes. Furniture and fixture clauses can sometimes cause problems among heirs. Everyone wants Aunt Susie's breakfront in the dining room. But these are things you have to discuss with your client to determine how she wants to leave certain items of personal property.

If you're married and your estate is worth \$120,000 or more, you should give serious consideration to the maximum marital deduction. The maximum marital deduction can actually be left in 3 ways. You can leave it outright, or you can leave it in two types of trust-- an estate trust, which means simply at the wife's death, the property passes to her estate-- or a power of appointment trust. It has to be left under certain specific conditions or it won't qualify for the marital deduction. In the power of appointment trust, the wife has to get the

income at least annually. If she doesn't or if anyone else controls that income, the trust won't qualify for the marital deduction. At death, the spouse has to have the right to elect in his or her will where that property goes. If the spouse is a good financial manager, it might not be necessary to set up a marital deduction trust, but the marital deduction can be left outright. Joint survivorship property and life insurance left to the spouse will be subtracted from the marital deduction amount left from the probate estate. If you set up a power of appointment trust and have \$200,000 qualifying for the marital deduction with a \$50,000 home in joint survivorship and \$50,000 worth of life insurance with the wife as the beneficiary, the only amount you should have in that trust is \$100,000.

The balance of your estate does not have to be left in trust. It can be left to your children, grandchildren, parents or to whomever the testator chooses to leave his estate. However, in the vast majority of cases, he has to set up a primary concern is the protection of his wife for her lifetime. If the testator wishes his wife to have the benefits of his entire estate, he has to set up a trust for the balance of his estate. It is necessary to be careful with your drafting of the trust, because if it isn't drafted properly, the residuary trust might be taxed to her estate at her death.

I don't recall having prepared a trust where I didn't make a provision for invasion rights of principal. If your wife gets sick and needs money and doesn't have a right to invade that principal, you can be sitting there with a trust that cannot be used to pay her medical bills. Therefore, I normally insert a clause saying that principal can be invaded for the "health and maintenance" of the wife. If you use such words as "general welfare" or "comfort", you can cause that part to be taxed again in her estate. So watch your wording.

One of the vital areas of a will is a second trust for children, maybe grandchildren. Remember one basic point: in Kentucky and in many other states now the legal age is 18. If you don't leave a trust, but just leave it outright to the children and they're under 18, then at age 18 they're going to come to the administrator and ask for their money. Most clients feel that a child is not old enough at 18 to handle large sums of money. Normally, most clients decide to terminate the trust for their children somewhere between the age of 25 and 30. In preparing this type trust, it should be flexible so that the children or the grandchildren can use the principal as well as the income for their health, maintenance, and education. This is more human planning and has very little to do with taxes. These are the practicalities that you want to consider when you discuss a will for your client.

You should have an executor in a will and this should not be left to chance. If you name an individual who doesn't know anything about estate administration, then you'd better have a good lawyer who does, because when you're dealing with an individual executor or executrix, a lawyer has to do everything but keep the checkbook. The alternative is to use a bank's trust department

which, if large enough, has the expertise in the various areas that have to be dealt with in handling the estate.

A trust can last for a long time. If you make a will with the income to go to your wife for her lifetime and your wife is 35 years old, you could be talking about a trust that could last for 50 years if your wife dies at 85. If you have children and you want the trust to terminate when they're 25 and the youngest is 3, you're talking about a trust with a minimum of about 22 years. In trusts of this type, it is probably best to use a corporate trustee. You don't necessarily have to give a corporate trustee carte blanche on everything. You can set up an advisory committee consisting of your loved ones. If they can't get along with the trust officer, they could be given the right to change to another corporate trustee. The testator could appoint a consultant to the trustee relative to changes in investments.

In the remaining time that I have, I'm going to talk to you about planning you can do prior to death. I don't give investment advice; I don't think this is a lawyer's function, but I do discuss certain types of tax-favored investments. One popular type of investment is what we call flower bonds, or tombstone bonds. These are certain United States Treasury bonds that qualify for payment of federal estate taxes if owned by the testator at his death. They sell at sizable discounts--presently they are selling for \$790 or \$800 per \$1,000 face amount of the bond. If you use them to pay federal death taxes, they can be delivered to the Federal Reserve at face value.

I did some estate planning for a client 3 or 4 years before he died, and he bought \$280,000 in United States Treasury bonds (flower bonds). They were selling at that time at \$700 per bond. When he died, we took \$200,000 face value of these bonds and delivered them to the Federal Reserve in payment of his federal estate taxes. At the date of his death, the bonds were worth \$800 per bond. The estate made a \$40,000 profit, minus the death taxes on the appreciation, so that developed into a windfall profit for the estate of \$28,000. My client could have bought these bonds a day before he died and they could have still been used for payment of his federal estate taxes.

In Kentucky, a power of attorney can be used even in the event of disability. Under Kentucky law the individual who has the power of attorney can buy flower bonds for his principal even though the principal is not capable to make such a decision. The power of attorney can also start upon the disability of the principal. There is a recent New York case where the IRS disallowed the use of a power of attorney to purchase flower bonds. The Court successfully claimed that the power of attorney at the time it was exercised was not valid because the individual was disabled. We don't have that problem in Kentucky if the power of attorney provides the power remains valid upon the disability of the principal. There are only about eight or nine states that have this broad provision in their law.

In Series E U.S. Savings Bonds where the interest accumulates and is not taxable for income tax purposes until the bonds are sold, it doesn't make any

difference whether the bonds are sold before or after the owner's death--the interest will be taxable for income tax purposes. However, the executor has a number of choices in how and who should pay the income tax on the accumulated bond income. The executor can accrue the bond interest and put it on the last income tax return of the decedent or he can continue to hold them and then make a distribution to the beneficiary and let the beneficiary sell them and pay the income tax on the income of sale; or the executor can accrue them in the executor's estate and sell part of them and hold part of them until a later date and thus spread the income over more than 1 year.

I had a case where the decedent died in February and her son (the only heir of her estate) was in the 60 percent income tax bracket. The estate was going to generate a considerable amount of taxable income. We decided to accrue the interest in her last income tax return because she had very little income in that 1 month before her death. We saved about \$5,000 just on that one transaction. If the son had received the bonds and then sold them and took the interest income on top of his other income, it would have resulted in a payment of 60 percent of the interest income in taxes.

Many of you probably have municipal bonds. Municipal bonds are fully taxable for federal estate tax purposes and in most states for inheritance tax purposes. If you have \$10,000 worth of municipal bonds, whatever the market value is worth, at the date of your death they will be taxed in your estate for federal estate tax purposes at that figure, even though they are free bonds for income tax purposes.

As you know, in a corporate qualified plan, all of the proceeds representing the corporation's contribution to the plan are not taxable at your death if they are left to a named individual, to an inter vivos trust, or in a testamentary trust. If it's left to a testamentary trust, be sure that you make a provision that the proceeds from the qualified plan cannot be used for payment of death taxes or administrative costs of the estate, because if it can be used for that purpose, it might also be taxable in your estate for federal estate tax purposes.

If you have a situation where the husband has a sizable estate and the wife has a very small estate, sometimes it's wise to put in your will that in the event of the simultaneous death of the husband and the wife, it will be assumed that the wife has survived the husband. The same wording should be used in both wills, assuming the husband has the larger estate, in the event they die simultaneously and it cannot be determined which spouse died first.

#### QUESTION AND ANSWERS:

QUESTION: How are common stocks, owned by the deceased but held by a reliable brokerage firm, treated for death tax purposes?

MR. ROTHSCHILD: They would be evaluated in your estate at the fair market value as of the date of death. Actually, you can evaluate the estate at the date of death or 6 months thereafter. If the value of those stocks, for instance, should

go down in that 6 months period, you might want to take the later valuation date and perhaps save some death taxes.

QUESTION: Is there any advantage to having a co-executor for your estate for instance, your wife and a bank?

MR. ROTHSCHILD: You can. It provides a little check and balance on the bank. It doesn't make any difference as far as the fee is concerned because the bank will take the full fee.

QUESTION: Is a trust to the wife for lifetime included in the decedent's estate for estate tax purposes? What's the tax treatment on that? You have listed in your outline short term trusts and irrevocable trusts and I was wondering about the tax treatment of the different types of trusts, too. Could you comment on that?

MR. ROTHSCHILD: What I was talking about in the outline were living trusts. These are not trusts connected with your will. These are inter vivos trusts you set up in estate planning for your family. Basically, this group covers three different types of trusts. A revocable trust, which you can revoke at any time you want to, has no estate tax significance, no income tax significance, and no gift tax significance. Then there is a short term trust. This is used where the individual is in a high income bracket but doesn't have a large estate. However, he does have enough property to put some aside in a trust for a period of no less than 10 years. The income from the short term trust principal is distributed to the income beneficiary, such as the grantor's children or to a parent of the grantor and then at the end of the 10 years, the property reverts back to the grantor. It's primarily an income tax advantage, but it also can have some estate tax disadvantage, because if the grantor dies before the short term trust terminates, a portion of the trust would not be taxable in the grantor's estate, based on the amount of the actuarial part of the income which the grantor would not be entitled to receive until the end of the 10 year period. There could be a gift tax on the trust proceeds; about 40 per cent of what you put into it would have to be included as a gift at the time that you set up the short term trust.

The irrevocable trust is the best overall tax saving tool of all because that trust not only has the tax advantage of keeping its income from being taxed to the grantor, but it also eliminates federal estate tax if it's properly drawn. If your estate is large enough that you feel you can do without the property given away, this trust is often a very attractive tool. Property given to a revocable trust is a gift and might result in gift tax to be paid by the grantor. However, each of the parents has a \$30,000 lifetime exemption, and the children have a \$3,000 a year exclusion.

QUESTION: How about these testamentary trusts?

MR. ROTHSCHILD: With a testamentary trust, the object is to keep property out of the wife's estate as of the date of her death. It goes on down to the children.

QUESTION: This is not exactly a tax question, but as a physician, I'm constantly

hearing about people for whom a will has been provided, but there's absolutely nothing for them to operate on for the first year or two because they can't get to the money. Is there some mechanism by which some insurance money can go directly to the family for immediate use, or do they always have to wait for all this probate business?

MR. ROTHSCHILD: Of course, you know that insurance, if your contract calls for it, is not going to go through probate. If the wife is the outright beneficiary, she should be able to get the proceeds within 30 days after your death. If I have a marital deduction where the wife gets the marital property outright and the balance goes in trust for the wife for her lifetime and then in trusts for the children, I'll normally recommend one-half of the proceeds be left outright to the wife and the other half of life insurance proceeds be left in trust.

If all the property gets tied up in probate, a widow has an allowance in Kentucky. That's one of the reasons that it's important for you to develop liquidity in what you have--so that it doesn't get all tied up in property that you can't convert to cash for that allowance. Thus, it also becomes advisable for you to consider life insurance so that you do have immediate cash available.

QUESTION: I have a question relating to a recent Kentucky Supreme Court decision about the valuation of several acres of farm land. It is being used for agricultural purposes, but suppose that it actually has a higher value in terms of the possibility that it is subdivided. Do you value it at the higher figure for estate tax purposes?

MR. ROTHSCHILD: I don't like to, but I do. That particular case was about property taxes. I'm talking about estate taxes. They're not treated the same way.

QUESTION: Do you still have to follow that higher figure?

MR. ROTHSCHILD: Yes, until Congress comes up with some kind of relief, which I'm hopeful that they'll do, we are faced with that problem in Kentucky and all over the country. It's a serious problem because valuations have shot up rather rapidly.